CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1940

KP 23907

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics CREATED DURING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 4, 1954.

FORM RM-1 (11-58) RETAIN—PERM.

Authorization No. 345

Department: Health

Bureau: Vital Statistics

REQUEST FOR RETENTION PERIOD

To: Records Management Officer,
Room 408, City Hall, Baltimore, 2, Md.

Record Identification

1. TITLE:	2. Form No. if available	3. Type—(cards, paper, etc.)
Certificate of Death		Bound Book

4. Dates	5. Volume accumulated yearly	6. Size of Record	7. Number of copies made
		Misc.	One (1)

8. Authorization Requested (check only one (1) of the squares below)

A. ☐ Establish retention period for records which are accumulating daily.

B. ☐ Dispose of present accumulation, no additional accumulation anticipated.

C. ☐ Microfilm and destroy originals.

D. ☒ Microfilm and retain originals for length of time indicated below.

9. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	10. Equipment and space freed.	11. In your opinion does this record have any historical significance?
12 yrs.	Micro. Perm.	12 yrs. and Micro. Perm.		YES ☐ NO ☒

12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval Robert E. Farber, M.D. Title: Commissioner of Health 3/28/63 Date

Recommendation of Records Management Officer

13. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	14. Disposal Method
12 yrs.	Microfilm Permanent	12 yrs. and Microfilm Permanent	A. ☐ To be sold as scrap or waste paper; B. ☒ To be Burned or shredded; C. ☐ Historical, (to be transferred to Dept. of Legislative Reference.)

REMARKS:

C P Force Records Management Officer 3/29/63 Date

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

FILED ON FILM

IN

NUMERICAL ORDER

372820 C58686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

C58686 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2035 S. Exeter St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Curro

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Antonio Curro

6 (c) If widowed, give age ? years

7. Birth date of deceased (mo., day, yr.) March 3 1896

8. AGE: Years	Months	Days	If less than one day
57 (51)	3 (3)	12 (12)	hr. min.

9. Birthplace Italy (town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name Frank CANNOVO

13. Birthplace Italy

MOTHER 14. Maiden Name Mary ROMANO

15. Birthplace Italy

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 17/47 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Noce

(b) Address 52 N. Marley St.

JUN 16 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1947 at 12:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-3- 1947 to 6-15- 1947 and that I last saw h.. alive on 6-15- 1947

Immediate cause of death Pass. pulm. embolism

Due to ASHD

Due to

Other Conditions Anemia; hypertrophy (HYPERTROPHY)

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Hunt M.D.

Address A.H.H. Date signed 6-15-47

NG 4500 X

Every item of information should be carefully supplied. The ages is especially important. Physicians: please write the causes of death clearly and legibly.

G52627

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 111a

G52627 Registered No.

S.S. Auctoritas

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street.
(c) Hospital or institution:
2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Italy (b) County
(c) City or town Levanto Spezia
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country. Italy

3 (a) FULL NAME Gio Batta TERENZONI ~~XXXXXXXX~~

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1891

8. AGE: Years 55 | Months 6 | Days 12 | If less than one day ....hr. ....min.

9. Birthplace Levanto Italy
(Town, county, and state)

10. Usual Occupation Boat Swain

11. Industry or business

FATHER
12. Name Geatano TERENZONI
13. Birthplace Italy

MOTHER
14. Maiden Name Giuseppina Arpe
15. Birthplace Italy

16 (a) Informant Nicola Terenzoni (Brother)
(b) Address Levanto Spezia Italy

17 (a) Burial (b) Date thereof June 17/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Frank Della Rose
(b) Address 52 N. Morley St.

19 (a) 1947 Junetwenty-four Williamsburg, Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11, 1947, at 1 p.M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pulmonary - embolism, with infarction of right lung

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George E. Merrill M.D.
Medical Examiner.
Date signed 6/11/47

VS 181

X

G52628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 131a

Registered No. G52628

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 944 W Franklin St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 50

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 944 W Franklin (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Green

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race col | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/20/94

8. AGE: Years 53 | Months 50 | Days 2 3 23 | If less than one day hr. min.

9. Birthplace Howard County (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Samuel Green
13. Birthplace Howard Co. Md.

MOTHER
14. Maiden Name Mary Moore
15. Birthplace Howard Co. Md.

16 (a) Informant Mary Morrow
(b) Address 944 W. Franklin

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 16 1947 (month) (day) (year)
(c) Cemetery or crematory Gilford
Location Howard Co. Md.

18 (a) Funeral director Mrs. K. R. Wilkins
(b) Address 142 N. Schroeder St

19 JUN 16 1947 (Date rec'd by registrar) (b) Huntington Williamsport Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/12 1947, at 6A M

21. I certify that death occurred on the date above stated, that I attended deceased from 6/1 1947, to 6/12 1947, and that I last saw h alive on 6/11 1947

Immediate cause of death: Hypertensive Cardio-Renal disease — Duration 6 mos 2 days

Due to pulmonary edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address 6009 Belmont Ave Date 6/13/47

VS 150

G52629

210816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G52629

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1503 E. Manument St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Black	widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-9-92

8. AGE: Years	Months	Days	If less than one day
54	9	6	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Mutual Chemical

11. Industry or business

FATHER
12. Name Henry Smith
13. Birthplace Va

MOTHER
14. Maiden Name Mary Thomas
15. Birthplace Va

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date there June 19 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem
Location Baltimore Md

18 (a) Funeral director Clary O. Wilson
(b) Address 1705 Bentalou ave

19 JUN 16 1947 (b) Huntington Williams M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1947 at 1 50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-26 1947 to 6-16 1947, and that I last saw him alive on 6-15 1947

Immediate cause of death	Duration
Carcinomatosis of right lung, pleura, mediastinum, right supra clavicular Nodes	25 Mo's
Due to primary site Not determined	
Due to	
Other Conditions Hypertensive cardiovascular disease	14 yr.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene Unger M. D.
Address Johns Hopkins Date signed June 15 1947

VS 150

X

G52630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G52630

CWK-111424

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write in ink.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Hr. 50 Min.
(e) Length of stay in Baltimore (yrs., mos., or days) About 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3307 Toone Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Lynn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Hannah J. Lynn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
77 78	?	?	hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace England

MOTHER
14. Maiden Name Not Known
15. Birthplace England

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6/18/47 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location 7225 EASTERN AVE

18 (a) Funeral director Clarence F. Mothmann
(b) Address 1639 O'DONNELL

19 JUN 16 1947 (Date rec'd by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1947, at 2:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 14 1947 to June 14 1947, and that I last saw him alive on June 14 1947

Immediate cause of death: Carcinoma of sigmoid with widespread metastases — Duration

Due to

Due to

Other Conditions Emaciation

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marion M. Lacy, M.D. M. D.
Address Baltimore City Hosp. Date signed 6-14-47

Bowers

G52631 BOH #55263 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 1159 Registered No. G52631

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Jefferson and Linden
(c) Hospital or institution: Maryland General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 N. Dekalb Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) FULL NAME Walter Lester Bowers

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 6/15/47

8. AGE: Years — Months — Days — If less than one day 11 hr. — min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Newsboy

11. Industry or business —

FATHER
12. Name Francis J. Bowers
13. Birthplace Balto - Md

MOTHER
14. Maiden Name Alice N. Bailey
15. Birthplace Balto. Md

16 (a) Informant Father of Infant
(b) Address 1514 N. Dekalb Ave

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6/16/47 (month) (day) (year)
(c) Cemetery or crematory PARKWOOD
Location TAYLOR AVE

18 (a) Funeral director Clement F. Hoffman
(b) Address 4637 Groveway

19 JUN 16 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/15/47 19 at 4P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/15/47 19 to 6/15/47 19 and that I last saw h[illegible] alive on 6/15/47 19

Immediate cause of death	Duration
Prematurity	
Due to Pre-Maturen Labor	
Due to 7 1/2 Months	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas C. Webster
Address Md. Gen. Hosp. Date signed 6/15/47

G52632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No. G52632

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRESS WITH PENCIL, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Mt. Pleasant Beach, Pasadena, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. --
(If rural give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country ---

3 (a) FULL NAME William Hill McCabe

3 (b) If veteran, name war	3 (c) Social Security Account No.
Spanish-American	Unknown

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Wid.

6 (b) Name of ~~husband~~ wife Unknown
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) 8/19/76

8. AGE: Years	Months	Days	If less than one day
70	9	- 27	___ hr. ___ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business C. & P. Telephone Co.

FATHER
12. Name Wm. H. McCabe
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Alice Lavinia Sitzler
15. Birthplace Baltimore, Md.

16 (a) Informant Alice May (Daughter)
(b) Address Mt. Pleasant Beach, Pasadena, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/18/47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md.

18 (a) Funeral director Wilson & Son Inc
(b) Address 1 Park Ave.

19 (a) JUN 16 1947 (Date rec'd by registrar) (b) Kenneth Wilson Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15, 1947, at 4:55PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-21 1947 to 6-15 1947 and that I last saw him alive on 6-15- 1947.

Immediate cause of death	Duration
Carcinoma of urinary bladder with metastases to left ureter and liver.	Unk.
Due to	
Due to	
Other Conditions Hydroneprosis, left.	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: none
of autopsy: 6-15-47 6:30p.m.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: no.
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert C. Dunn
Robert C. Dunn, Surgeon M. D.
Address Officer of Day Date signed 6-16-47

G52633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G52633

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2704 Mathews St
(c) Hospital or institution: 9-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2704 Mathews St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva C Lidley

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Benjamin O. R. Lidley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 1 1869

8. AGE: Years	Months	Days	If less than one day
77	7	14	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER	12. Name David Bunce
	13. Birthplace Baltimore Co Md
MOTHER	14. Maiden Name Mary Deal
	15. Birthplace Baltimore Md

16 (a) Informant Mrs Newton Bunce
(b) Address 2704 Mathews St
17 (a) Burned (Burial, cremation, or removal) (b) Date thereof 6/17/47 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md
18 (a) Funeral director Millard Cook Sons
(b) Address 217 E Saratoga St
19 (a) JUN 16 1947 (Date received by registrar) (b) Burlington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to June 14 1947; and that I last saw h[illegible] alive on June 14 1947

Immediate cause of death	Duration
Myocarditis	6 mo.
Due to Fractured Hip	5 yr.
Due to Senility	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Herbert M. Fooks M.D.
Address 824 St. Paul St. Date signed June 16-47

G52634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G52634

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3008 Guilford Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3008 Guilford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert C. Dews

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 214-01-8216

4. Sex: M
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: M.
6 (b) Name of husband or wife: Anne E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 21 1896

8. AGE: Years 51 | Months 1 | Days 23 | If less than one day hr. min.

9. Birthplace Balto. (Town, county and state)
10. Usual Occupation Dept. Head
11. Industry or business L. Grief Co.

FATHER
12. Name Charles C Dews.
13. Birthplace Va.

MOTHER
14. Maiden Name Margaret C Sweeney
15. Birthplace Md.

16 (a) Informant Anne E. Dews.
(b) Address 3008 Guilford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/17/47 (month) (day) (year)
(c) Cemetery or crematory London Pk.
Location Balto.

18 (a) Funeral director Wm Cook Jne
(b) Address 1217 St Paul St

19 (a) JUN 16 1947 (b) Huntington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 June 1947, at 6 A.M. P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammerer M.D. (Medical Examiner.)
Date signed 14 June 1947

Please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Give age as accurately as possible. This is important.

C52635

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓46F

Registered No. C52635

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Allegany
(c) City or town Cumberland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 620 Washington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: JOSEPH POWELL FRANKLIN

3 (b) If veteran, name war: World War No. 2
3 (c) Social Security Account No. none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Jean Arendes Franklin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 11, 1896

8. AGE: Years 50 | Months 10 | Days 4 | If less than one day ... hr. ... min.

9. Birthplace Coalburg, Ala.
(Town, county, and state)

10. Usual Occupation Physician
11. Industry or business State of Maryland

FATHER
12. Name Thomas B. Franklin
13. Birthplace Kellerman, Ala.

MOTHER
14. Maiden Name Roberta Bagley
15. Birthplace Coalburg, Ala.

16 (a) Informant Mrs. Roberta Franklin
(b) Address 2013 - 9th St., Galena Park Texas

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 6/16/47 (month) (day) (year)
(c) Cemetery or crematory Elmwood Cem.
Location Birmingham, Ala.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 16 1947 (b) Registered by (Signature) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1947 at 6 15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from ... 19... to June 15 1947 and that I last saw h alive on June 15 19 47.

Immediate cause of death: Cardiac Failure — Duration
Due to Thrombosis (Coronary)
Due to Pulmonary Embolism
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Amputation Malignant Nodules on Liver
of autopsy: Some with further examination

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Huntington Williams M.D.
Address Sinai Hospital Date signed 6/15/47

PENALTY FOR WILFUL FALSE STATEMENT, WILFUL UNDERSTATEMENT OR OVERSTATEMENT OF AGE: Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

652636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

Register 652636

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4118 Mary Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 79 yrs 5 mos 11 ds

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4118 Mary Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Francis Joseph Mooney

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margaret Veronica Mooney
6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) Jan 27, 1868

8. AGE: Years	Months	Days	If less than one day
79	4	20	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation Stone mason
11. Industry or business

FATHER
12. Name Richard Mooney
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary Smith
15. Birthplace Baltimore Md

16 (a) Informant Mrs Frank Waltman
(b) Address 7479 Berkshire Rd

17 (a) B (Burial, cremation, or removal) (b) Date thereof June 19 47 (month) (day) (year)
(c) Cemetery or crematory St Vincents
Location St Edwards Lane

18 (a) Funeral director Martin J Cassidy
(b) Address 1640 Hollins St

JUN 16 1947
Date rec'd by registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1947 at 9:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 12 1947 to June 16 1947 and that I last saw him alive on June 16 1947

Immediate cause of death Pneumonia — Duration 3 days
Due to Chronic nephritis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ronald Jandorf M. D.
Address 6077 Hamilton Rd Date signed 6-16-47

VS 150

G52637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G52637

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2610 Whitney Ave.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., of days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3525 Belvedere Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nannie T. Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Walter E. Martin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1894

8. AGE: Years 52 | Months 11 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Geo. D. Smith
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie T. Hyland
15. Birthplace Maryland

16 (a) Informant Mary McManus
(b) Address 2610 Whitney Ave.

17 (a) Burial (b) Date thereof 6 16 47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory David Rodger
Location Pikesville Md.

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

(a) Tomlinson Williams, M.D. (b) Tomlinson Williams, M.D.
(Date rec'd by registrar)

JUN 16 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14th 1947 at 5P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1, 1946 to June 14 1947 and that I last saw her alive on June 14 1947

Immediate cause of death: Coronary Thrombosis — Duration: 1 day

Due to: Cardio Vascular Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter E. Martin M. D.
Address Randallstown, Md. Date signed 6/16/47

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Register No. 652638 ✓ 82a

652638

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Streets
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County ——
(c) City or town BALTIMORE 18
(If outside city or town limits, write RURAL and give town)
(d) Street No. 313 E. 28th STREET
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HATTIE L. SISSON (Hattie Levine Pampell Sisson)

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Martin R. Sisson
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 29, 1877 (1878)

8. AGE: Years 69 | Months 9 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace Frederick - MARYLAND
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name JEROME PAMPELL
13. Birthplace MARYLAND

MOTHER
14. Maiden Name ARIA MORGAN
15. Birthplace MARYLAND

16 (a) Informant HOSPITAL RECORDS
(b) Address 33rd & Calvert Sts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-17-47 (month) (day) (year)
(c) Cemetery or crematory LORRAINE Park
Location Woodlawn - Md.

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address [illegible] 100 W. North Avenue

19 JUN 16 1947 (Date rec'd by registrar) Huntington Wells, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1947, at 6:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947, to June 14 1947, and that I last saw her alive on June 14 1947.

Immediate cause of death	Duration
Cerebro vascular accident	2 weeks
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Evan B Chamberlain M. D.
Address Union Memorial Hosp Date signed 6-14-47

X

52639

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312a

Registered No. G52639

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Charles & 31st Sts.
(c) Hospital or institution: at home (Stonewood Apts.)
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Battle City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Charles & 31st Sts. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie Akers Guy Davis

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: John A. Davis
6 (c) If alive, give age 84 years

7. Birth date of deceased (mo., day, yr.) March 31 1867

8. AGE: Years 80 | Months 2 | Days 14 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name Robert J. Guy
13. Birthplace Rockingham Co. Va.

MOTHER
14. Maiden Name Elizabeth Akers
15. Birthplace Balto. Md.

16 (a) Informant Miss Edith Alan Davis daughter
(b) Address Stonewood Apts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 17 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore

18 (a) Funeral director Shipard & Morris Co.
(b) Address 108 W North Ave.

19 (a) Filed by [illegible] (b) Date filed JUN 16 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1947, at 3:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1946 to June 14 1947 and that I last saw her alive on June 14 1947.

Immediate cause of death: Uremia — Duration: 1 month

Due to: Nephrosclerosis — Duration: unknown

Due to:

Other Conditions: Generalized Arteriosclerosis and Arteriosclerotic heart disease

(Include pregnancy within 3 months of death)

Date of operation: none

Major findings of operation: none

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos F. E Sungenwald

Address 1109 St Paul St Date signed M 6 D 16/47

X

G52610

BALTIMORE CITY HEALTH DEPARTMENT

BH # 980965 CERTIFICATE OF DEATH X 159

Registered No. G52610

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Raynor Ave 16

(c) Hospital or institution: West Balto Gen Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Anne Arundel

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 216 Doris Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Robert Ernest Burck

3 (b) If veteran, name war None | 3 (c) Social Security Account No. None

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/11/47

8. AGE: Years | Months | Days | If less than one day 14 hr. min.

9. Birthplace Baltimore Md

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Robert E Burck

13. Birthplace Baltimore

MOTHER 14. Maiden Name Eileen Connolly

15. Birthplace Baltimore

16 (a) Informant

(b) Address 216 Doris Ave

17 (a) (b) Date thereof

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School JUN 13 1947

18 (a) Funeral director Commissioner of Health

(b) Address

JUN 16 1947 Huntington Williams M.D.

(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 1947, at 9:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/10/47 19 to 6/11/47 19, and that I last saw h[illegible] alive on 6/10/47 19

Immediate cause of death	Duration
Resp. arrest	
Failure	
Due to Prematurity	
Due to	
Other Conditions Mother carrier C Rheumatic Heart Disease	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature [illegible] M. D.

Address West Balt Gen Hosp Date signed 6/12/47

X

G52641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G52641

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WITH PENCIL, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 9 Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2804 Chesswold Rd
(If rural give location)
(e) Citizen of foreign country? [redacted] No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. John Schmetz

3 (b) If veteran, name war

3 (c) Social Security Account No. 578-18-3718

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 21, 1870

8. AGE: Years	Months	Days	If less than one day
76	8	25	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Tanner

11. Industry or business

FATHER	12. Name Jacob Schmetz
	13. Birthplace Germany
MOTHER	14. Maiden Name Catherine Daum
	15. Birthplace Germany

16 (a) Informant Reginald Schmetz
(b) Address 2804 Chesswold Rd Balto

17 (a) Burial (b) Date thereof 6/18/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Druid Ridge
Location Pikesville Md

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) JUN 17 1947 (Date received by Registrar) (b) Signature for Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1947, at 1205 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-16 1947, to 6-16- 1947, and that I last saw him alive on 6-16 1947

Immediate cause of death: Myocardial infarction — Duration

Due to: Coronary sclerosis

Due to: /

Other Conditions: Hypertension & pulmonary edema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Myocardial infarction

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. G. Turner M. D.

Address Union Memorial Date signed 16 June 47

G52612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G52612 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.A.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1913 Linden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carl Carroll Forsythe D.J.M.

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-4295

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of ~~husband~~ or wife Olive Forsyth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 14th 1888

8. AGE: Years	Months	Days	If less than one day
59	4	1	hr. min.

9. Birthplace Bellbridge Pa. (Town, county, and state)
10. Usual Occupation String Maker
11. Industry or business Middleton + Mead

FATHER
12. Name Robert Forsyth
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary Duncey
15. Birthplace Unknown

16 (a) Informant Olive Forsyth
(b) Address 1919 Linden Ave

17 (a) Burial (b) Date thereof 6/19/47 (Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Glen Haven
Location Glenarnie A.A.Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 (a) JUN 17 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/15 1947 at 5:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Thibeault M.D. Medical Examiner.
Date signed 6/16/47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 131 a

Registered No. G52613

The 52613

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317 Hollins St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
1943
(d) Street No. 1317 Hollins Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Sherbahn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Cyrus Sherbahn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1867

8. AGE: Years 80 | Months 3 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Cyrus Sherbahn
(b) Address 1317 Hollins Street

17 (a) burial (b) Date thereof 6/18/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Western
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

JUN 17 1947 (b) Huntingtown Williams, M.D.
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15, 1947, at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 19 47 to June 15 1947 and that I last saw h alive on 6/15/47 19

Immediate cause of death: Acute Myocarditis — Duration 2 days

Due to: Nephritis — Duration 4 years

Due to: Arterio Sclerosis — Duration

Other Conditions: Senility — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Helen F. Sherbahn

Address 1612 Edmondson Date signed 6/16/47

X

Every item of information should be carefully supplied. Entries must be typed, or written in INK. Erasures not permitted. Use separate certificate for each death. Do not fold. Do not roll. Physicians: please write the causes of death clearly and legibly.

G52644

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No. G52644

Please write plainly with pen and ink. Every item of information should be carefully supplied. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1500. Preasman. St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
15-1
(d) Street No. 1500 Preasman St. PRESSTOWN (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PEGGY SMITH.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3--28--1933.

8. AGE: Years	Months	Days	If less than one day
14	2	15	hr. min.

9. Birthplace Baltimore. Md. (Town, county, and state)

10. Usual Occupation School.

11. Industry or business

FATHER
12. Name Morris smith.
13. Birthplace Heathville. Va.

MOTHER
14. Maiden Name Geneva Smith.
15. Birthplace Md.

16 (a) Informant Mrs. Geneva Smith.
(b) Address 1500. Preasman. St.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof 6--17--47. (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem Park.
Location Baltimore County Md.

18 (a) Funeral director William A Jackson.
(b) Address 916. Penna. Ave.

(a) Date received JUN 17 1947 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June. 15. 1947 5:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/9 1947 to 6/13 1947 and that I last saw h alive on 19

Immediate cause of death	Duration
Pulmonary Tbc.	over 24hs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Edward Conner M. D.
Address 1131 Hartenstine Date signed 6/14/47

G52615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 85

G52615 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3505 Columbus Ave (If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Seno
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (month) (day) (year) 15-1873

8. AGE: Years	Months	Days	If less than one day
74	4		hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Fruit & Produce
11. Industry or business

FATHER
12. Name Carmello Seno
13. Birthplace Italy

MOTHER
14. Maiden Name Rosaria Priolo
15. Birthplace Italy

16 (a) Informant Carmello Seno (Son)
(b) Address 2546 Arunah Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 18 1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Old Frederick Road

18 (a) Funeral director Joseph Zonas Sons
(b) Address 2013 Greenmount Ave

JUN 17 1947 (Date rec'd) (b) Huntington Williams, Mgr

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-15 1947 at 6 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 30 1947 to June 15 1947 and that I last saw him alive on June 15 1947.

Immediate cause of death Simultaneous Coronal Occl. Mural Occl. Following a Gall during Due to an Gangrenous Attack

Duration

Due to

Other Conditions Duodenal Ulcers Perforation Years Ago (Include pregnancy within 3 months of death)

Date of operation April 3 1947

Major findings of operation: Suture perforation of 7th Duodenal ulcer 6th Thoracic - Cholecystectomy

Findings of autopsy: Fracture of 7th and 8th Thoracic Vert

PHYSICIAN
Underline the cause to which death should be referred.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lawrence J. Knapp M. D.
Address Mercy Hosp Date signed 6-15-47

C58646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C58646

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 658 W. Saratoga
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
4-2
(d) Street No. 658 W. Saratoga (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Fredrick Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Rosa
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1860

8. AGE: Years	Months	Days	If less than one day
87	1	-	hr. min.

9. Birthplace Gloster Co. Va.
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace " " "

MOTHER
14. Maiden Name Unknown
15. Birthplace " " "

16 (a) Informant Leon Smith
(b) Address 945 Bennett Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-17-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Lebanon
Location City

18 (a) Funeral director Samuel W. Bullman
(b) Address 1011 N. Arlington Ave.
(c) Date received (Date received by local registrar) Huntington Williams M.D.

JUN 17 1947

V. S. 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/13/47 19 , at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1/47 19 to 6/13/47, and that I last saw h alive on 6/11/47

Immediate cause of death	Duration
Myocarditis	
Due to Chronic Nephritis	Unknown
Due to Sen. Atty	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Thos. F. Corum
Address 402 Edmondson Date signed 6/16/47

G52617 (2) G52617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1248

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Madison Ave 1st floor
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 Madison Ave 1st fl. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Epps

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-05-9530

4. Sex Male | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Nina Epps

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 14, 1898

8. AGE: Years 49 | Months 3 | Days 27 | If less than one day hr. min.

9. Birthplace Weldon N. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name George Epps
13. Birthplace Wilson N. C.

MOTHER
14. Maiden Name Emma (Unknown)
15. Birthplace Weldon N. C.

16 (a) Informant Nina Epps
(b) Address 1708 Madison Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof 6-17-47 (month) (day) (year)
(c) Cemetery or crematory Arlington Mem. Park
Location Baltimore, Co. Md.

18 (a) Funeral director Mrs. Geo. W. Holland
(b) Address 1631 Druid Hill Ave.

19 (Date rec'd by Registrar) JUN 17 1947 (Huntington for Williams Mort.)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1947, at 12 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 16 1947 to June 13 1947 and that I last saw him alive on June 13 1947

Immediate cause of death: Myocardial insufficiency — Duration Fifty-seven

Due to: Enlarged liver — Duration 2 yrs ±

Due to: Chronic passive hepatic congestion

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 1723 Druid Hill Ave Date signed 6-16-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52648 20 BALTIMORE CITY HEALTH DEPARTMENT G52648
CERTIFICATE OF DEATH 94a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1356 N. Stricker St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
15-1
(d) Street No. 1356 N. Stricker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie L. Evans King

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed or divorced. Married

6 (b) Name of husband or wife Samuel H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 17, 1891

8. AGE: Years	Months	Days	If less than one day
55 56	5	27	hr. min.

9. Birthplace Lexington, Va. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Robert Evans
13. Birthplace Lexington, Va.

MOTHER
14. Maiden Name Sally Todd
15. Birthplace Lexington, Va.

16 (a) Informant Samuel H. King
(b) Address Route #1 Box 11 - Jamesville N.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 17 1947 (month) (day) (year)
(c) Cemetery or crematory Lebanon Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Geo. H. Hallam
(b) Address 16 E. Preston St.

JUN 17 1947 (a) (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/13/47 at 11 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/11/47 to 6/13/47 and that I last saw h alive on 19

Immediate cause of death Coronary Thrombosis — Duration

Due to Accident

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Date signed 6/14/47

X

G52619

JL - 99474

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G52619 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 3- 23
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
9-6
(d) Street No. 1802 Chilton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Florence Brown

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25, 1868

8. AGE: Years	Months	Days	If less than one day
~~79~~	0	21	hr. min.

9. Birthplace Md. (Balto.) (Town, county, and state)
10. Usual Occupation At home
11. Industry or business Self

FATHER
12. Name Alfred C. Brown
13. Birthplace Md. (Balto)

MOTHER
14. Maiden Name Annie Donohue
15. Birthplace Md. (Balto)

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/18/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.
18 (a) Funeral director William Cook Inc.
(b) Address 1219 E. Bal[illegible] St.
19 (a) (Signature) (b) Huntington Williams, M.D.

JUN 17 1947
V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1947 at 9P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 23 1946 to June 16 1947, and that I last saw h[illegible] alive on June 16 1947.

Immediate cause of death	Duration
Debility	
Due to (1) Senility, (2) Generalized arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Edwin C. Evans M. D.
Address Balto. City Hospitals Date signed 6-16-47

X

G52650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G52650

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1225 Light St.
(c) Hospital or institution: Lo. Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19d
(e) Length of stay in Baltimore (yrs., mos., or days) 74yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
26-10
(d) Street No. 318 S. East Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frieda Ernst (FREDERICKA ERNST)

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. None

4. Sex: F.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: W.

6 (b) Name of husband or wife: Not alive.
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Sept. 25, 1872

8. AGE: Years 74 | Months 8 | Days 21/30 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Julius Babikow
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace Germany

16 (a) Informant Mrs. Ferdinand Behr
(b) Address 3600 Jefferson Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/18/47 (month) (day) (year)
(c) Cemetery or crematory First Evangelical Cem
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

JUN 17 1947 (c) Huntington Williams, M.D. Registrar
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1947, at 2:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 28 1947, to June 15 1947, and that I last saw HER alive on June 15, 1947.

Immediate cause of death: Myocardial Failure — Duration (?)
Due to: Chronic Myocarditis — (?)
Due to: Hypertensive C. V. D. —
Other Conditions: Fracture, Left Hip — 7 mos.
(Include pregnancy within 3 months of death)
Date of operation May 29, 1947
Major findings of operation: Tightening of Lloyd's Boot
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident 26-10
(b) Date of occurrence 11-6-46 at ? M
(c) Where did injury occur? Outside 318 S. East Ave (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Outside Home (Specify type of place) While at work? no
(e) Means of injury Fell while trying to open door

23. Signature Louis L. Lapidus, M. D.
Address Lo. Balto. Gen. Hosp. Date signed 6-15-47

Howard J. Nelson, M.D. X

G52651

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G52651

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene and Lombard
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County xxxx
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
8-5
(d) Street No. 1749 Darley Ave. # B (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma ~~Frances~~ Beckmeyer (EMMA FRANCES BECKMYER)

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: F.
5. Color or race: W,
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Walter L. Beckmyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 23, 1858

8. AGE: Years 88 | Months 5 | Days 20 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm. Hunter
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Fannie Bryson
15. Birthplace Baltimore, Md.

16 (a) Informant C. Raymond Knipp
(b) Address 2583 Hamilton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/18/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) JUN 17 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1947, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 31 1947, to June 15 1947, and that I last saw her alive on 6-15 1947.

Immediate cause of death	Duration
Uremia and Hypostatic Pneumonia	
Due to Renal shutdown	
Due to Arteriosclerosis and Arteriosclerotic C*V Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Brockman, MD M. D.
Address Unit. Dept. Date signed 6-15-47

X

G52652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G52652

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 504 S. Streeper St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
1-2
(d) Street No. 504 S. Streeper Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Washington Nelson

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: None

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Margaret Nelson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28-1868

8. AGE: Years 78 | Months 10 | Days 17 | If less than one day: hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business City of Baltimore

FATHER
12. Name Charles W. Nelson
13. Birthplace Delaware

MOTHER
14. Maiden Name Elizabeth Kaunes
15. Birthplace Germany

16 (a) Informant Mrs Helen Foss
(b) Address 504 S. Streeper St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/17/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE? & BROADWAY

19 (a) JUN 17 1947 (Date received by Registrar) (b) Signature for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1947, at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-25- 1947 to 6-14- 1947, and that I last saw him alive on 6-14-1947.

Immediate cause of death	Duration
Cardio-vascular renal disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene Zeller, M.D.

Address 2739 Eastern Ave Date signed 6/17/47

X

G52653

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 37

G52653 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2647 WILKINS AVE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
20-5
(d) Street No. 2647 Wilkins Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LILLIE B. MORAN

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife CHARLES L. MORAN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC 27 1876

8. AGE: Years 70 | Months 5 | Days 18 | If less than one day hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)

10. Usual Occupation

11. Industry or business House Wife

FATHER
12. Name JOHN PARKER
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Jane Magaha
15. Birthplace Virginia

16 (a) Informant EILEEN ALLEGGETT
(b) Address 2647 WILKINS AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JUNE 18 1947 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location Balto Md

18 (a) Funeral director Robt G B. M. Walter
(b) Address 3412 Frederick Ave

19 (a) JUN 17 1947 (Registrar's signature) for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 14th 1947, at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 12 1947 to June 14 1947, and that I last saw h[illegible] alive on June 14 1947.

Immediate cause of death Hypostatic Congestion
Pulmonary Edema
Due to Pneumonia

Due to

Other Conditions Pulmonary Edema

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert O. Whitely M. D.
Address 215 W Lanvale Date signed June 14 47

52651

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G52651 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1620 E. Balto. St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
6-5
(d) Street No. 1620 E. Balto. St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Zacharsky Also Known as Sakinsky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Minnie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1877

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Ret Tailor

11. Industry or business

FATHER
12. Name David
13. Birthplace Russia

MOTHER
14. Maiden Name Miriam
15. Birthplace Russia

16 (a) Informant Minnie Zacharsky-Sakinsky
(b) Address 1620 E. Balto. St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-17-47 (month) (day) (year)
(c) Cemetery or crematory Negro Hebrew Rd
Location Phil. Pa

18 (a) Funeral director Jack Levin Inc
(b) Address 1739 E. Balto St

JUN 17 1947 (Date rec'd by Registrar) Huntington Williams, M.D.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1947 at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1946 to June 16 1947 and that I last saw him alive on June 15 1947

Immediate cause of death	Duration
Coronary Thrombosis	1 hr.
Due to Hypertensive Cardio-Vascular Disease	10 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. M. Miller M.D.
Address 1618 E Balto St Date signed 6/16/47

X

G52655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G52655

Every item of information should be carefully supplied. The... write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2400 Talbot Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
15-9 (d) Street No. 2400 Talbot Rd. 16
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SPENCER THOMAS OLDHAM

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife May Veise Oldham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1885

8. AGE: Years	Months	Days	If less than one day
62	4	6	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Tennis Professional
11. Industry or business

FATHER
12. Name Spencer Oldham
13. Birthplace England

MOTHER
14. Maiden Name Anna Elizabeth
15. Birthplace England

16 (a) Informant Mrs. May V. Oldham
(b) Address 2400 Talbot Rd.

17 (a) Burial (b) Date thereof 6/18/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 JUN 17 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15, 1947, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1946 to June 15 1947 and that I last saw h[illegible] alive on June 15 1947.

Immediate cause of death	Duration
Coronary Occlusion	Sudden
Due to Coronary artery disease	6 yrs
Due to Arterio-Sclerosis	?
Other Conditions Arterial Hypertension	6 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature L. E. Nichols M.D.
Address Pikesville, Md. Date signed 6/16/47

G52356 b

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 8 3a

Registered No. G52356

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1307 Maryland Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mon.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE RUBY MARLEY

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Dr. Benjamin C. Marley, Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 20, 1865

8. AGE: Years 82 | Months 4 | Days 26 | If less than one day hr. min.

9. Birthplace Towson, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Sylvester Bowen
13. Birthplace Towson, Maryland

MOTHER
14. Maiden Name Mary E. Langley
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Benjamin C. Marley, Jr.
(b) Address 1307 Maryland Ave., Balto., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 18, 1947 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill Cemetery
Location Towson, Maryland

18 (a) Funeral director John Burns' Sons
(b) Address Towson, Meryland

19 (a) JUN 17 1947 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16, 1947 at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1947 to June 1947 and that I last saw her alive on June 16 1947

Immediate cause of death	Duration
Cardio-Resp. failure	2 days
Due to Cerebro-vascular accident	6 mos
Due to Arteriosclerosis	years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J Leslie
Address 1 E of St Paul Date signed 6/17/47 M. D.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G528557

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 227 N. Greene (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bill Leo MAKRIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Asimo

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 62 (65) | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Greece (Town, county, and state)

10. Usual Occupation Restaurant

11. Industry or business

FATHER
12. Name John
13. Birthplace

MOTHER
14. Maiden Name Mary
15. Birthplace

16 (a) Informant N Lambros
(b) Address 896 Evesham ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-17-47 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Windsor Mill Rd

18 (a) Funeral director Lambros Funeral Home
(b) Address 1440-E North ave

19 (a) 6/17/47 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/14/47 19__, at 11.40 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D., Medical Examiner.
Date signed 6/15/47

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52658

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

G52658 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
20-3 (d) Street No. 22 South Payson Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES BURKHARDT Charles Cleveland Burkhardt

3 (b) If veteran, name war: World War II

3 (c) Social Security Account No. 215-22-7101

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 10, 1927

8. AGE: Years	Months	Days	If less than one day
19	7	5	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Periodical Publishing Co

FATHER
12. Name Edward W. Burkhardt
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Anna F. Harkin
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Edward W. Burkhardt
(b) Address 22 S. Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 19,1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cm.
Location Baltimore, Md.

18 (a) Funeral director E. Wallis Lamasney
(b) Address 1003 W. Baltimore St.

19 JUN 17 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15, 19 47, at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull, Intracranial hemorrhage, laceration of brain

Due to

Other Conditions Multiple brush burns, abrasions, and bruises

(Include pregnancy within 3 months of death)

22. If an external cause was ~~primary~~ ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-14-47 at 12:55 a. M. 10/1
(b) Where did injury occur? Caroline & Preston Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Fire Engine Truck & Taxicab collided

23. Signature Howard J. Mercer M.D. Medical Examiner.
Date signed 6-16-47

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Use only standard abbreviations. Do not use any abbreviations not approved by the Baltimore City Health Department. Use no ditto marks. Fill in all spaces where information is supplied. Use ink.

G52659 **HEALTH DEPARTMENT—CITY OF BALTIMORE** G52659

CERTIFICATE OF DEATH 467

1. PLACE OF DEATH CRAWFORD RETREAT 28-1 Registered No.

CITY OF BALTIMORE: (No. 2117 Mennison St St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME ~~Angelita~~ Angelita Elizabeth Shawe

If U.S. Veteran specify WAR

(a) Residence: No. 4606 Haddon Ave St. 28 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

3a. If married, widowed, or divorced HUSBAND of (or) WIFE of Percy T. Shawe

6. DATE OF BIRTH (month, day, year) December 6, 1895

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
51	6	10	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. At Home

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

FATHER

13. NAME Charles H. Brannan

14. BIRTHPLACE (city or town) Baltimore
(State or country) Md.

MOTHER

15. MAIDEN NAME Angelita -

16. BIRTHPLACE (city or town) ———
(State or country) ———

17. INFORMANT Mr. Percy T. Shawe
(Address) 4606 Haddon Ave.

18. BURIAL, CREMATION, OR REMOVAL
Place Woodlawn Cem. Date June 19 1947

19. UNDERTAKER E. Willis Lamoreaux
(Address) 4510 Liberty Heights Ave.

20. FILED JUN 17 1947 Huntington Williams M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) June 16, 1947

22. I HEREBY CERTIFY, That I attended deceased from Jan 15 1947 to June 16 1947

I last saw h[illegible] alive on June 16 1947 Death is said to have occurred on the date stated above, at 8:00 P m.

The principal cause of death and related causes of importance were as follows:

Carcinoma, Rectum 1 yr. Mo.

Other contributory causes of importance:

Was an operation performed? Yes Date of Dec 1946

For what disease or injury Carcinoma, Rectum

What test confirmed diagnosis Biopsy Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) Stanton Brannan M. D.

(Address) 1109 St Paul St

OCCUPATION is very important. See instructions on back of certificate.

X

G52660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G52660

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Fill correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7012 Hrford Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
27-7 (If outside city or town limits, write RURAL and give town)
(d) Street No. 7012 Harford Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Vincenzo Caltagirone

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of ~~husband~~ wife late Rosa
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 11 1887

8. AGE: Years	Months	Days	If less than one day
60	5	4	hr. min.

9. Birthplace Aidone Enna Italy
(Town, county, and state)
10. Usual Occupation Frruit dealer
11. Industry or business

MOTHER / FATHER
12. Name Ambrogio Caltagirone
13. Birthplace Italy

MOTHER
14. Maiden Name Rosa Bruno
15. Birthplace Italy

16 (a) Informant Vincent Giordano (Son in law)
(b) Address 7012 Harford Ave

17 (a) burial (Burial, cremation, or removal) (b) Date thereof June 18/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Francis Della Luca
(b) Address 52 N. Morley St.

19 (a) (b) Registrar

JUN 17 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15, 1947, at 6:20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1947 to June 15 1947, and that I last saw him alive on June 14, 1947

Immediate cause of death Essential Hypertension — Duration

Due to Chronic Myocarditis — Chronic Nephritis

Due to Arteriosclerosis — Pneumonic emboli

Other Conditions Cerebral Hemorrhage

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nathan Janney M. D.
Address 7101 Harford Rd. Date signed 6/16/47

G52661

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No. G52661

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1538 Mc Elderry St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
7-5
(d) Street No. 1538 Mc Elderry St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Collins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Married

6 (b) Name of husband or wife James Collins
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) Oct 1, 1899

8. AGE: Years	Months	Days	If less than one day
47	8	12	hr. min.

9. Birthplace Portsmouth Md. (Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business

FATHER
12. Name George Bailey
13. Birthplace Portsmouth Md

MOTHER
14. Maiden Name Annie Jones
15. Birthplace Portsmouth Md

16 (a) Informant James Collins
(b) Address 1538 Mc Elderry

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 17, 47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location Baltimore Md

18 (a) Funeral director Elroy S. Wilson
(b) Address 1000 Brantley ave

19 (a) [illegible] (b) [illegible]
JUN 17 1947
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 1947 at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1946 to June 13 1947.
and that I last saw h[illegible] alive on June 13 1947.

Immediate cause of death	Duration
Carcinoma of urethra with metastasis to Bladder & Rectum.	1 yr
Due to	
Due to	
Other Conditions Aneurysm of aorta & Cardiac Hypertrophy (Include pregnancy within 3 months of death)	1 yr

Date of operation none
Major findings of operation: none
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ralph J. Young
Address 1429 E Monument St Date signed 6/25/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 131a

Registered No. G52662

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 Llewellyn Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
8-7
(d) Street No. 2025 Llewellyn ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emanuel Price

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	N.	Married

6 (b) Name of husband or wife Viola

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1890

8. AGE: Years	Months	Days	If less than one day
57	1	13	hr. min.

9. Birthplace Hanover County Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Grocery Business

FATHER
12. Name Nelson Price
13. Birthplace Va.

MOTHER
14. Maiden Name Catherine ?
15. Birthplace Va.

16 (a) Informant Louis Price
(b) Address 2023 Llewellyn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 20 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A.A. County, Md.

18 (a) Funeral director Mrs. Pott, G. C. Ward & Dyer
(b) Address 1129 N Caroline St

JUN 17 1947 (Date rec'd by Registrar) (b) Courtney for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1947 at 11:16 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947 to June 14 1947, and that I last saw h. alive on June 14 1947.

	Duration
Immediate cause of death Uremia	
(a) Cardiac failure	
(b) Respirations	
Due to Cardio-renal disease	unkn.
Due to ?	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence A at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. C. Burwell M. D.
Address 1711 Argonne Date signed 6/17/47

VS 150

G52663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G52663

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1637 N. Hilton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
16-7
(d) Street No. 1637 N. Hilton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Marie Dreisbach

3 (b) If veteran, name war	3 (c) Social Security Account No.
~	~

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife Michael
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 30, 1870

8. AGE: Years	Months	Days	If less than one day
76	9	16	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name Henry Zoll
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Norman Dreisbach
(b) Address 1637 N. Hilton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 16 1947 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore

18 (a) Funeral director Fred A. Dodd
(b) Address 1200 E. Lombard St

19 (a) JUN 17 1947 (Local registrar's date) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15, 1947, at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947, to June 14 1947, and that I last saw her alive on 6-14 1947.

Immediate cause of death Carcinoma of Colon - with Bleeding from bowel and severe Anemia — Duration 8 MONTHS
Due to
Due to
Other Conditions Arteriosclerotic Cardio-vascular renal disease — years
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. F. Sullivan
Address 2911 Pacific Blvd Date signed 6-15-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52664 BC#B81392

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 160a

Registered No. G52664

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St. & Linden Ave
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 d.

2. USUAL RESIDENCE OF DECEASED: None
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
27-10
(d) Street No. 705 Glenwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby boy Leonard

3 (b) If veteran, name war — 3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 6-16-47

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Robert Charles Leonard
13. Birthplace Columbus, Ohio Germany

MOTHER
14. Maiden Name Clara Clara Leonard
15. Birthplace Maryland

16 (a) Informant F. J. Rock M.D.
(b) Address Maryland Gen Hosp

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-17-1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) Date received by JUN 17 1947 (b) Huntington Williamson, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-17 19 47, at 8:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-16 19 47 to 6-17 19 47, and that I last saw h.e. alive on 6-17 19 47.

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to birth injury	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature F. J. Rock M. D.
Address Maryland Gen Hosp Date signed 6-17-47

G52665

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G52665

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 119 N. Bradford St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
6-3
(d) Street No. 119 N. Bradford St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jadwiga Harla

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anthony Harla
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Oct 18 1886

8. AGE: Years 60 | Months 7 8 | Days 28 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Joseph Rusin
13. Birthplace Poland

MOTHER
14. Maiden Name
15. Birthplace Poland

16 (a) Informant Mr. Anthony Harla
(b) Address 119 N. Bradford St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-19-47 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore City

18 (a) Funeral director John M. Weber
(b) Address 401 N. Chester St

19 (a) Filed JUN 17 1947 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION 1020

20. DATE OF DEATH June 15 1947, at A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1947, to June 15 1947, and that I last saw ~~him~~ alive on June 15 1947

Immediate cause of death	Duration
Coronary Thrombosis	6/15/47
Due to Ch. Myocarditis	1/1/47
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William L. Roark M.D.
Address 501 N. Rockwood Rd Date signed 6/16/47

G52666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G52666

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 223 N. Lanvale St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 223 N. Lanvale St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Gustavus Whiteley

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Married

6 (b) Name of husband or wife D. Allen Dugger-Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9 1866

8. AGE: Years	Months	Days	If less than one day
80	11	8	hr. min.

9. Birthplace Bacto Md (Town, county, and state)
10. Usual Occupation Consul for Belgium
11. Industry or business

FATHER
12. Name William Stevens Whiteley
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth Emaline Holmes
15. Birthplace Phila Pa

16 (a) Informant Mrs. James G. Whiteley
(b) Address 223 N. Lanvale st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 19 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md

18 (a) Funeral director Henry W. Jenkins & Son Co.
(b) Address McCulloh & Orchard Sts

19 (a) Date received by Registrar JUN 17 1947 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1947, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1942 to 19, and that I last saw h alive on 19.

Immediate cause of death	Duration
(a) Arteriosclerosis,	Indefinite
Due to (b) Arteriosclerotic Heart Disease	10-15 yrs.
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmund L. Keeney M. D.
Address 1201 N. Calvert St. Date signed 6/17/47

Baltimore 2 Md - X

To Health Comm. H. J. Mueller M.O.

C52667

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. C52667

Please write in ink, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3725 Ellerslie Avenue
(c) Hospital or institution: St. Elizabeth's Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
9-1 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3725 Ellerslie Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Sister Mary Eleanor McCarthy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F.

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 25, 1870

8. AGE: Years 76 | Months 9 | Days 20 | If less than one day: hr. min.

9. Birthplace New York City (Town, county, and state)

10. Usual Occupation Charitable work

11. Industry or business

FATHER
12. Name Jerome McCarthy
13. Birthplace County Cork, Ireland

MOTHER
14. Maiden Name Catherine Lynch
15. Birthplace County Tipperary, Ireland

16 (a) Informant Mother Mary Imelda
(b) Address St. Elizabeth's Home

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 18/947 (month) (day) (year)
(c) Cemetery or crematory St Elizabeths Home
Location 3725 Ellerslie Avenue

18 (a) Funeral director Henry W. Jenkins' Sons
(b) Address McCulloh & Orchard Sts

19 (a) Filed June 17 1947 (b) Mother Mary Imelda Registrar
Recorded
Huntington

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 June 1947 at 1.47 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9 June 1947 to 15 June 1947 and that I last saw her alive on 14 June 1947

Immediate cause of death	Duration
Pulmonary Edema	2 days
Due to Hypertensive Cardio-Vascular Disease	20 yrs.
Due to	
Other Conditions Cardiac Asthma. Perianal, st., Cerebral hemorrhage (Include pregnancy within 3 months of death).	9 yrs.

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. H. Kammer, Jr. M. D.
Address 501 Sheridan Ave. Date signed 17 June 47

G52668

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G52668 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1128 N. Longwood St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days) 85 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
16-7
(d) Street No. 1128 N. Longwood St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME ANNA VIRGINIA CONRAD

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Wm. D. A. Conrad
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 29, 1862

8. AGE: Years	Months	Days	If less than one day
85	4	17	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Home
11. Industry or business

FATHER
12. Name Christopher Nicks
13. Birthplace Germany

MOTHER
14. Maiden Name Madaline Fisher
15. Birthplace Germany

16 (a) Informant Miss Estella May Conrad
(b) Address 1128 N. Longwood St.

17 (a) Burial (b) Date thereof 6/19/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

JUN 17 1947 (b) Twatington for Williams, M.D.
(Date received by Registrar) Registrar

V S 190

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15- 1943, to June 16- 1947 and that I last saw her alive on June 16 1947.

Immediate cause of death Carcinoma of both breasts — Duration 3 1/2 yrs.
Due to.....
Due to.....
Other Conditions Coronary Thrombosis — Duration Last hrs.
(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature H. McDermott M. D.
Address 1136 Park Ave. Date signed 6/17/47

G52369

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122a

Registered No. G52369

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... supplied. The correct age is especially important. Physicians: please write the... the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette and Calhoun
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
17-1
(d) Street No. 968 Wilmer Ct. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William WASHINGTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Negro	

6 (b) Name of husband or wife Elana Washing

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2 Aug 73 1903

8. AGE: Years	Months	Days	If less than one day
43	10	9	hr. min.

9. Birthplace Virginia (Town, county, and State)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name William Washington
13. Birthplace Virginia

MOTHER
14. Maiden Name Unk.
15. Birthplace Unk.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory University Medical School JUN 16 1947
Location

18 (a) Funeral director Commissioner of Health
(b) Address
JUN 17 1947 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 Jun 1947, at 7 25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6 Jun 1947, to 11 Jun 1947, and that I last saw him alive on 11 Jun 1947

Immediate cause of death Terminal broncho-pneumonia — Duration

Due to Bilateral atelectasis

Due to

Other Conditions Delerium tremens
Postoperative herniorrhaphy
(Include pregnancy within 3 months of death)

Date of operation 2 Jun 47

Major findings of operation: R. inguinal hernia.

If autopsy cerebral edema

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stanley B. Klyanawic M. D.
Address Franklin Sq. Hosp. Date signed 6/17/47

X

VS 150

G52670

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G52670 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: Univ.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
16-1 (d) Street No. 602 Carrollton Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Dave Burkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) ~~Single~~, married, widowed, or divorced.

6 (b) Name of husband or wife unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years 47 | Months | Days | If less than one day hr. min.

9. Birthplace Ga. (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER 12. Name

13. Birthplace Unknown

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School JUN 17 1947

18 (a) Funeral director Commissioner of Health

(b) Address

(c) JUN 17 1947 (Date rec'd by registrar) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-16 1947, at 1:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-26 1947, to 6-16 1947, and that I last saw him alive on 6-16 1947.

Immediate cause of death	Duration
Resp failure	
Due to CVA	
Due to embolus from	
Other Conditions Valvular pneumonia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Pomeranz [illegible] M. D.

Address Univ. Hosp Date signed 6-16-47

X

G5[illegible]71 — X ✓ G5[illegible]71

BALTIMORE CITY HEALTH DEPARTMENT

BH#S-80653

CERTIFICATE OF DEATH 159

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green & Edmond Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Cockeysville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country No

3 (a) FULL NAME Baby Girl Gaultney

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: newborn

6 (b) Name of husband or wife: None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/7/47

8. AGE: Years 0 | Months 0 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Glen Black
13. Birthplace Unknown

MOTHER
14. Maiden Name Stella Kate Gaultney
15. Birthplace Caroline Co. Virginia

16 (a) Informant Stella Kate Gaultney
(b) Address Cockeysville, Md

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JUN 17 1947

18 (a) Funeral director Commissioner of Health
(b) Address
JUN 17 1947 (Date received by registrar) Thurlington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1947, at 5 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 7 1947, to June 8 1947, and that I last saw h-r alive on 7/5 1947.

Immediate cause of death	Duration
Prematurity	
Due to Diabetes of mother	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 6/8/47

552672

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. 552672

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 827 N. Eutaw St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ronald Cole

3 (b) If veteran, name war W | 3 (c) Social Security Account No. none

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 28 1933

8. AGE: Years 13 | Months 8 | Days 19 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Cole
13. Birthplace Pa.

MOTHER
14. Maiden Name Clarella Cole
15. Birthplace Pa.

16 (a) Informant Aunt Mrs
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 6/19/47 (month) (day) (year)
(c) Cemetery or crematory Connellsville
Location Connellsville Pa

18 (a) Funeral director Gilliam Bros
(b) Address 1217 Druid St

19 (a) JUN 17 1947 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-17 1947 at 4:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-10 1947 to 6-17 1947 and that I last saw h/l alive on 6/17 1947.

Immediate cause of death Cardiac failure - hemorrhagic pneumonia — Duration

Due to Lupus Sarcoma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M.D.
Address Skaggs Date signed 6/17/47

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WITH PENCIL, WITH UNFADING INK.

C53373

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83B

Registered No. C53373

NH 111152

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 44 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2209 Howard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Sarah McKnight

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1882

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Unknown
15 Birthplace

16 (a) Informant Records Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof June 17, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lakewood Cem. Co. Va.
Location Gloucester Co. Va.

18 (a) Funeral director Wm. George A. Holland
(b) Address 1651 Druid Hill Ave.

19 (a) JUN 18 1947 (b) Huntington-Williams, Md.
(Registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1947 at 8:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 1947, to June 17 19 47, and that I last saw her alive on June 17 19 47.

Immediate cause of death	Duration
Respiratory Failure	
Due to Bronchio Pneumonia	
Due to	
Other Conditions Cerebral Thrombosis	
(Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation
of autopsy None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. R. Scarborough M. D.
Address Balto. City Hosp. Date signed 6-17-47

107

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G5D374

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G5D374

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Reistertown (If outside city or town limits, write RURAL and give town)
(d) Street No. Hanover Rd. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Earnest Flynn

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Edith Richardson Flynn
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) July 4, 1879

8. AGE: Years	Months	Days	If less than one day
67	11	12	..... hr. ..... min.

9. Birthplace: Maine (Town, county, and state)
10. Usual Occupation: None
11. Industry or business: -

FATHER
12. Name: George F. Flynn
13. Birthplace: Maine

MOTHER
14. Maiden Name: Sylvia Robbin
15. Birthplace: Maine

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 20 '47 (month) (day) (year)
(c) Cemetery or crematory: StPauls Cemetery
Location: Arcadia Md

18 (a) Funeral director: Wm Berryman & Sons
(b) Address: Reisterstown Md

JUN 18 1947 (b) Hamilton Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1947, at 10:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1947 to June 16 1947, and that I last saw him alive on June 16 1947

	Duration
Immediate cause of death: Hemorrhage, cerebral extradural and subdural	1 wk.
Due to: Basilar fracture of the occipital bone with tear of the dura at the posterior lip of the foramen magnum	1 wk.
Other Conditions: Subarachnoid hemorrhage both frontal lobes (contrecoup)	1 wks.

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: Accident
(b) Date of occurrence 6/16/47 at 10:55 P.M.
(c) Where did injury occur? Reisterstown (City or town) Md (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury: Fall

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M.D.
Address: Clinical Director Date signed 6/18/47

Howard J. Sweeney, M.D.

575 BALTIMORE CITY HEALTH DEPARTMENT G583575
CERTIFICATE OF DEATH 83B Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5700 Birchwood (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Karl F. Buselmeier

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Klara
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 13-1876

8. AGE: Years	Months	Days	If less than one day
71	4	4	hr. min.

9. Birthplace Karlsrotte, Germany (Town, county, and state)
10. Usual Occupation Musician
11. Industry or business

FATHER 12. Name Moritz Buselmeier
13. Birthplace Germany

MOTHER 14. Maiden Name Louise
15. Birthplace Germany

16 (a) Informant Mrs. Klara Buselmeier
(b) Address 5700 Birchwood

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-20-47 (month) (day) (year)
(c) Cemetery or crematory Mem. Conception Location Forest Park
18 (a) Funeral director L. J. Ruck
(b) Address 5305 Harford Rd
19 JUN 18 1947 (b) Huntington Williams M.D. (Date received by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17, 1947, at 12:20 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from May 20, 1947, to June 17, 1947, and that I last saw h. alive on June 17, 1947.

Immediate cause of death	Duration
Pulmonary Infarct	
Due to Embolus from Leg Veins	
Due to Debilitation	
Other Conditions Cerebral Thrombosis	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature H. Bray
Address University Hospital Date signed 6-17-47

100 R

G52676 BC# D 81596

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 160a

✓ G52676 Registered No.

Every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK. Be sure to write the causes of death clearly and legibly. Physicians; please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edmondson & Fulton Ave
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3621 Dolfield Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Tucker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/17/47

8. AGE: Years	Months	Days	If less than one day
			4 hr. 30 min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alexander Tucker
13. Birthplace New York, N.Y.

MOTHER
14. Maiden Name Lillian Newman
15. Birthplace Baltimore Md.

16 (a) Informant Mrs Lillian Tucker
(b) Address 3621 Dolfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-18-47 (month) (day) (year)
(c) Cemetery or crematory Mount Hebron Plan
Location

18 (a) Funeral director Jacquins Inc.
(b) Address 1434 E. Balto St

19 (a) Date received by registrar JUN 18 1947 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1947 at 8:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1947 to June 17 1947, and that I last saw h[illegible] alive on June 17 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Anoxia	
Due to Prolonged Second Stage	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton Leisch M. D.
Address Edmondson & Fulton Ave Date signed 6/18/47

G5203?7

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G5203?7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2400 Bowleys Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2400 Bowleys Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Anna E. Utah

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Frederick Utah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 26-1889

8. AGE: Years 57 | Months 7 | Days 21 | If less than one day hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Norton
13. Birthplace Balto

MOTHER
14. Maiden Name
15. Birthplace Balto

16 (a) Informant Mr Frederick Utah
(b) Address 2400 Bowleys Lane

17 (a) Burial (b) Date thereof June 19-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Jos J Stein & Son
(b) Address 3001 Eutaw Ave

19 JUN 18 1947 (Date rec'd by Registrar) (By) Courtesy for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1947 at 11:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 19 47 to June 16 19 47, and that I last saw her alive on June 15 19 47

Immediate cause of death Cerebral Hemorrhage — Duration 20 hours

Due to Hypertension

Due to Cardio-Vascular Renal Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature N. V. Harbold M. D.

Address 4706 Harford Road Date signed 6/17/47

X

G52378

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1062

Registered No. G52378

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5308 Gwynn Oak Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5308 Gwynn Oak Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HOWARD BEVARD DAY

3 (b) If veteran, name war: World War One
3 (c) Social Security Account No.: None

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ruth S. Day
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 2, 1889

8. AGE: Years 58 | Months 5 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace Pocomoke City Md.
(Town, county, and state)

10. Usual Occupation Real Estate Broker

11. Industry or business Self

FATHER
12. Name Charles H. Day
13. Birthplace Md.

MOTHER
14. Maiden Name Louise Bevard
15. Birthplace Md.

16 (a) Informant Mrs. Howard B. Day
(b) Address 5308 Gwynn Oak Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/19/47 (month) (day) (year)
(c) Cemetery or ~~cemetery~~ Meadowridge Mem.
Location Baltimore Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

JUN 18 1947 (Date Rec'd by Registrar) (b) Huntington Station, Maryland

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17, 1947, at 1 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 1 1947 to June 16 1947, and that I last saw him alive on June 16 1947.

Immediate cause of death	Duration
Acute Coronary failure	
Due to Cerebral Hemorrhage	
Due to Chr. Bronchitis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature H. D. Frankfurter M. D.
Address Date signed

H. D. Frankfurter

G52379 G52379

BALTIMORE CITY HEALTH DEPARTMENT

BC# B81189 CERTIFICATE OF DEATH 159 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address John H LAFAYETTE S ST.
(c) Hospital or institution: Women's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3218 Howard Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Bogia

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/16/47

8. AGE: Years — Months — Days 1 If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Roland Bogia
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Maria Scarborough
15. Birthplace Baltimore, Md.

16 (a) Informant mother
(b) Address 3218 Howard Park ave.

17 (a) Burial (b) Date thereof 6/18/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Lorraine Cem.
Location Baltimore Md.

18 (a) Funeral director WM. J. TICKNER & SONS, INC.
(b) Address North & Pa. Aves Balto. Md.

19. JUN 18 1947 (Date received by Registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1947, at 6:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/16/47 19... to 6/17/47 19..., and that I last saw h.e.r. alive on 6/17/47.

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. L. Simmons M.D.
Address Women's Hospital Date signed 6/17/47

VS 2

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52680

AB-110255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/13

G52680

Registered No.

Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mos 14days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 107 N. Schroeder Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Monroe Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 21- 1928

8. AGE: Years	Months	Days	If less than one day
19	4	21	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Howard (D
13. Birthplace ?

MOTHER
14. Maiden Name Isabelle (D
15. Birthplace ?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern AVE.

17 (a) Burial (b) Date thereof 6-18-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) 1947 Katie Rayton Williams, M.D.
(Filed by registrar) Registrar

18 1947

V S 150

MEDICAL CERTIFICATION PM

20. DATE OF DEATH June 12- 1947, at 11.40M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-28- 1947 to 6-12- 1947, and that I last saw him alive on 6-12- 1947

Immediate cause of death	Duration
Respiratory failure	
Due to Pulmonary TBC	
Due to	
Other Conditions S. T. S. positive	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Doyle Waldron M. D.

Address B. C. H. Date signed 6-13-47

X

G52681

AB-110820

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G52681

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1310 N. Stricker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Allen C. Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861-?-?

8. AGE: Years	Months	Days	If less than one day
86	?	?	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation D.P.W.

11. Industry or business

FATHER
12. Name Allen Thomas
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Hawkins
15. Birthplace Maryland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 6-18-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Star
Location Catonsville, Md.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (b)
(Date received by registrar) Registrar

JUN 18 1947

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 13- 1947 at 1.25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-21 1947 to 6-13- 1947, and that I last saw h im alive on 6-13 1947

Immediate cause of death	Duration
Respiratory failure	
Due to Lobar Pneumonia	1 mo
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Lobar Pneumonia

of autopsy Confirmed pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. C. Hobgood Jr. M. D.
Address 6 Mason Ave Date signed 6/19/47

Huntington Williams, M.D.

G52382 B14 G-32962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓78B

G52382 Registered No.

Please write the causes of death clearly and legibly. The correct age is especially important. Physicians: please write carefully. Information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 16
(d) Length of stay in Hospital or inst. (yrs., mos., or days) 20 D.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1117 Harlem Ave Relter Md
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barry Moore ✓

3 (b) If veteran, name war /
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1945.

8. AGE: Years 1 | Months 8 9 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name John J. Moore.
13. Birthplace N. C.

MOTHER 14. Maiden Name Anny Johnson.
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Anny Johnson.
(b) Address 1117 Harlem Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-18-47 (month) (day) (year)
(c) Cemetery or crematory Arlington Memorial
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

JUN 18 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-13- 1947 at 9 20 M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Lead poisoning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-11-47 at A. M.
(b) Where did injury occur? 1117 Harlem Ave Relter Md
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Ate paint from walls - Led.

23. Signature Earl L [illegible] M.D.
Medical Examiner.
Date signed 6-18-47

X

G52683 BALTIMORE CITY HEALTH DEPARTMENT G52683
CERTIFICATE OF DEATH 170c Registered No.

write the causes of death clearly and legibly. Physicians: please write correct age is especially important. Information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4208 Maine avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary E. Ruff

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 2, 1932

8. AGE: Years 15 | Months 3 | Days 15 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation School Girl

11. Industry or business

FATHER 12. Name Wm. D. Ruff
13. Birthplace Balto., Md

MOTHER 14. Maiden Name Cecelia A. Henzel
15. Birthplace Balto., Md

16 (a) Informant Mrs. Wm. D. Ruff
(b) Address 4208 Maine avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/20/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Harry A. Armacost
(b) Address 4204 Edgewood Ave

19 (a) 6/18/1947 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION 38

20. DATE OF DEATH June 17, 1947, at 12 p. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Multiple fractures, base of skull

Due to

Other Conditions Epidural, Subdural, and Subarachnoid hemorrhage
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 28/2
(a) Date of injury 6/12/47 at 12:20 p. M.
(b) Where did injury occur? Liberty Hgts. Ave. and 125 East of Edmondson
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Auto & Bicycle collision

23. Signature Howard C. Mahood M.D. Medical Examiner.
Date signed 6/17/47

X

G52684

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 93E

G52684 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1604 Cliftview Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1604 Cliftview Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Schneider

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Jacob Schneider
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 5 1854

8. AGE: Years	Months	Days	If less than one day
92	7	10 12	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Andrew Eisner
13. Birthplace Germany

MOTHER
14. Maiden Name ------ Arnold
15. Birthplace Germany

16 (a) Informant Rosa W. Schneider
(b) Address 1604 Cliftview Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 21 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Harry A. Tennant
(b) Address 4204 Ridgewood Ave

19 (a) 1947 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1947, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 4 1947, to June 17 1947, and that I last saw h alive on June 16 1947.

Immediate cause of death	Duration
Anaemia	
Intestinal Cancer	1 mo
Due to Angel	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Emil J. Zimmerman M. D.
Address 2858 Harford Date signed 6-18-47

G52685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G52685 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Baltimore City Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 20 South bethel Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HATTIE WILLIAMS

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace maryland (Town, county, and state)
10. Usual Occupation Factory Worker
11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Ethel Cooper
(b) Address 417 S. Dallas St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 21-1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md

18 (a) Funeral director Ehrgott & Wilson
(b) Address 1000 Reisterstown ave

JUN 18 1947 (b) Huntington Williams, M.D.
(Date rec'd by Registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12, 1947, at 2.05 P M

21. I certify that I took charge of the remains described above, held an insp. & inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebrovascular Hemorrhage
Spontaneous.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil L Kruger M.D.
Medical Examiner.
Date signed 6-13-47

G52686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56E

G52696
Registered No.

Every item of information should be carefully supplied. The ... write the cause of death clearly and legibly.
...ect age is especially important. Physicians: please write ...

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Tenn. (b) County
(c) City or town Knoxville.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 305 Caldwell Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edgar H Turner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Reba

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) 9-30-91

8. AGE: Years	Months	Days	If less than one day
55	8	18	...hr. ...min.

9. Birthplace Tenn.
(Town, county, and state)

10. Usual Occupation Rail Road Empl. Retired

11. Industry or business

FATHER
12. Name Rile R. Turner
13. Birthplace Tenn.

MOTHER
14. Maiden Name Reila Jourdan
15. Birthplace Ga.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 6-18-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rose Funeral Home
Location Knoxville Tenn

18 (a) Funeral director Chas R Thurston
(b) Address 4038 - N 4th St

19 (a) (b)
(Date rec'd by registrar)

VS 1947 Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1947, to June 18 1947, and that I last saw him alive on June 18 1947.

Immediate cause of death	Duration
Intra-abdominal hemorrhage.	
Due to Islet cell adenoma Pancreas	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 6/17/47
Major findings of operation: Islet cell adenoma.
of autopsy: Same.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry F. Dahmann M. D.
Address J H H Date signed

G52687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 61

G52687

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3805 BONNER RD
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) 59 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3805 BONNER RD
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MORRIS FRIEDBERG

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	WIDOW

6 (b) Name of husband or wife TRY

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace LITH
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name KASRIEL
13. Birthplace LITH.

MOTHER
14. Maiden Name SARAH
15. Birthplace LITH

16 (a) Informant E. DAVID FRIEDBERG
(b) Address 3805 BONNER RD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6-19-47 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh
Location Wrightsville Pike

18 (a) Funeral director Jack Levin Sons
(b) Address 1439 E. Balt St.

JUN 18 1947
(Date rec'd by registrar)

Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-17 1947, at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/18 1945 to 6/15 1947, and that I last saw h.im alive on 6/15 1947

Immediate cause of death Acute Cardiac Infarction — Duration

Due to Ch Hypertension

Due to Ch Diabetes

Other Conditions Chronic Cystitis Hemorrhoids
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Abe Hornstein M. D.

Address 733 Asquith St Date signed 6/20/47

G52688 — BALTIMORE CITY HEALTH DEPARTMENT — G52688 Registered No.

CERTIFICATE OF DEATH 94a

Please write plainly. Information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3951 Mosby
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3951 Mosby (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Francis Joseph Prenger

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-03-3842

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Sara M.

6 (c) If alive, give age 88 years

7. Birth date of deceased (mo., day, yr.) Oct. 4. 1866

8. AGE: Years 80 | Months 8 | Days 23 | If less than one day ____ hr. ____ min.

9. Birthplace Balto. Md.
(City, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Bernard H. Prenger

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Mary Murphy

15. Birthplace Balto. Md.

16 (a) Informant Sara M. Prenger

(b) Address 3951 Wilsby Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 20-47 (month, day, year)

(c) Cemetery or crematory Mrs. Leath's

Location Old Frederick Rd.

18 (a) Funeral director John A. Madden

(b) Address 426 Freemont Ave

18 (a) 1947 (b) Registered by registrar Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/17/47 19 at 6:38A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D. Medical Examiner

Date signed 6/17/47

G52689 — BALTIMORE CITY HEALTH DEPARTMENT — G52689 Registered No.

CERTIFICATE OF DEATH 1947

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address City Morgue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2823 Pelham Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles J. CLARK

3 (b) If veteran, name war None
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Gertrude Castex
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 9th 1880

8. AGE: Years 66 | Months 9 | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace Watertown New York.
(Town, county, and state)

10. Usual Occupation Caretaker

11. Industry or business Notre Dame University

FATHER
12. Name Clark
13. Birthplace New York State

MOTHER
14. Maiden Name Underwood
15. Birthplace

16 (a) Informant Mr. William L Castex
(b) Address 2823 Pelham Ave

17 (a) Burial (b) Date thereof 6/18/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Hanford Road Balto City

18 (a) Funeral director George Keith Inc
(b) Address 1735 Hanford Ave

JUN 18 1947
(Date rec'd by registrar) Registrar

VS 181

Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1947 at 8:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Probably drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Between June 3rd and 18th 24/6 ? M.
(b) Where did injury occur? Waters at Municipal Airport
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? ?
(d) Means of injury Found drowned.

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 6/18/47

X

Cause is especially important. Physicians: please write the causes of death clearly and legibly.

G52690 — BALTIMORE CITY HEALTH DEPARTMENT — G52690 Registered No.

CERTIFICATE OF DEATH

164a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town Bronx (If outside city or town limits, write RURAL and give town)
(d) Street No. 643 Coulton Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Gonzalez

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: ?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 15. 1916

8. AGE: Years 30 | Months 6 | Days 12 | If less than one day hr. min.

9. Birthplace Puerto Rico (Town, county, and state)

10. Usual Occupation Mess Man

11. Industry or business Merchant Marine

FATHER
12. Name Enabis Gonzalez
13. Birthplace Puerto Rico

MOTHER
14. Maiden Name Joanna Rivera
15. Birthplace Puerto Rico

16 (a) Informant Joanna Rivera
(b) Address New York

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 6/18/47 (month) (day) (year)
(c) Cemetery or crematory Lynn Cemetery
Location Linden N.Y.

18 (a) Funeral director Wilson & Johnson
(b) Address 1217 E. 92nd St. N.Y.

18 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1947, at 1 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation
Due to Hanging
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-16-47 at 11:30 A M(P)
(b) Where did injury occur S.S. Sea Queen - Port Covington
(c) Did injury occur at home, on farm, industrial place, in public place? Ship While at work? ?
(d) Means of injury Hanged self with bedsheet

23. Signature Howard J. Maldeis, M.D. per Earl Kline M.D.
Medical Examiner.
Date signed 6-18-47

VS 181

Correct age is especially important. Physicians please write the causes of death clearly and legibly. The causes of death should be carefully supplied. The

G52691
JL - 111486

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 148a

Registered No. G52691

Every item of information should be carefully supplied. The space for age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 26 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8h-25m
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 923 Hignet Way -5
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Gwendola Marie Floyd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Howard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1904

8. AGE: Years	Months	Days	If less than one day
42	11	5	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Carter
13. Birthplace Va.

MOTHER
14. Maiden Name Annie Seay
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 6/18/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mount Olivet
Location Maryland Ave

18 (a) Funeral director Wilhoyte & Son
(b) Address 1217 E. Pratt St

19 (a) (b)
(Date received by registrar) Registrar

JUN 18 1947

V S. 150

Huntington Williams, Approved by Medical Examiner
Earl L. Bergen M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1947, at 9.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1947, to June 17 1947, and that I last saw h. alive on June 17 1947.

Immediate cause of death	Duration
(a) Carcinoma of cervix & Widespread metastases	
Due to (b) Hemorrhagic anemia due to Carcinoma of Cervix	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature R. Butler M.D.
Address City Hospitals Date signed 6-17-47 M. D.

G52692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G52692

Every item of information should be carefully supplied. The ... write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3334 Chestnut Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3334 Chestnut Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Miss Mollie Shipley

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11-1877

8. AGE: Years 70 | Months 2 | Days 5 | If less than one day: hr. min.

9. Birthplace Carroll Co. Maryland (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Daniel Shipley
13. Birthplace Maryland

MOTHER
14. Maiden Name Catherine Hilbert
15. Birthplace Maryland

16 (a) Informant Miss Margaret Shipley
(b) Address 3334 Chestnut Avenue

17 (a) Burial (Burial, cremation or removal) (b) Date thereof June 19-1947 (month) (day) (year)
(c) Cemetery or crematory Ebenezer
Location Winfield Carroll Co. Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) (Date rec'd by registrar) (b) [illegible] Registrar

JUN 18 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16- 1947, at 4:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 25 1946 to Jun 16 1947, and that I last saw he alive on Jun 16 1947

Immediate cause of death	Duration
Myocarditis	
Due to Cerebral arteriosclerosis	
Due to general arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature [illegible] M. D.
Address 3429 Chestnut Ave Date signed 6/17/47

X

G52693

RUTH ROSE PAYNE

G52693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 50

Registered No.

Every item of information should be carefully supplied. The cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert

(c) Hospital or institution: Union Memorial Hospital 13

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County 10

(c) City or town Balt City

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3535 Hickory Ave

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Ruth Rose Payne

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Edward Payne

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8, 1883

8. AGE: Years	Months	Days	If less than one day
64	2	10	hr. min.

9. Birthplace Md (Carroll Co.)

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Richard Gaylord

13. Birthplace Maryland

MOTHER

14. Maiden Name Sarah C Erb

15. Birthplace Md

16 (a) Informant Edward Payne

(b) Address 3535 Hickory Ave

17 (a) Burial (b) Date thereof June 20-1947

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home

(b) Address 3631 Falls Road

JUN 18 1947

(Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1947 at 4:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 17 June 1947 to 18 June 1947 and that I last saw h[illegible] alive on June 18 1947.

Immediate cause of death — Duration

Respiratory failure

Due to Cerebral metastases from

Due to Ca of R. breast

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation [illegible] 47

Major findings of operation:

Ca of R breast

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Wm Kaufman Jr M. D.

Address Union Memorial Date signed 6-18-47

Reported IX

G52694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G52694 Registered No.

Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1243 Light St.
(c) Hospital or institution: South Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 dys
(e) Length of stay in Baltimore (yrs., mos., or days) 2 dys

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3701 St. Vincents St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby girl Sanders

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 16 1947.

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Anthony Sanders.
13. Birthplace Maryland

MOTHER
14. Maiden Name Ruth E. Moyer
15. Birthplace New York

16 (a) Informant Ruth Snyder
(b) Address Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/18/47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Baltimore St.

18 (a) Funeral director John F. Deyny Inc
(b) Address 716 Light St.

(Date) 6-18-47 (b) Registrar Washington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1947, at 2:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1947, to June 18 1947, and that I last saw her alive on June 18 1947.

Immediate cause of death	Duration
acute Cardiac Failure	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1243 Light St. Date signed 6-19-47

VS 150

G52695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G52695 Registered No.

Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2504 W Franklyn St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) no
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2504 W Franklyn St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Winfield S Arthur

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-09-2131

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
m	W	

6 (b) Name of husband or wife Bertha E Arthur
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5 - 1876

8. AGE: Years	Months	Days	If less than one day
71		13	hr. min.

9. Birthplace Thurmont Md
(Town, city, or county) (State)
10. Usual Occupation Shoe Maker & Mechanic
11. Industry or business

FATHER
12. Name Hiram E Arthur
13. Birthplace Thurmont Md

MOTHER
14. Maiden Name Nancy Heine
15. Birthplace Thurmont Md

16 (a) Informant Mrs Bertha E Arthur
(b) Address 2504 W Franklyn St

17 (a) Burial (b) Date thereof 6/21/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hillside Cem
Location Camp Hill Cumberland Co Pa

18 (a) Funeral director Charles P Powell
(b) Address 2427 Edmondson Ave

6/18 1947 Huntington Williams, M.D.
(Date received by registrar) (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/17 1947, at 8:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-14- 1947, to 6-17- 1947, and that I last saw him alive on 6-16- 1947.

Immediate cause of death Cerebral Hemmorrhage — Duration 4 da.
Due to Hypertension — Duration unknown
Due to —
Other Conditions none

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Chester Riland, M. D.
Address 2532 Edmondson Ave Date signed 6-17-47

G52696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G52696 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rutland Ave & Monument St
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4112 La Salle Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie C. Heim

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife Fred A. Heim
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Sept. 26, 1884

8. AGE: Years	Months	Days	If less than one day
62	8	23 72	hr. min.

9. Birthplace Baltimore - Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Walter Burns
13. Birthplace Balto - Md

MOTHER
14. Maiden Name Fannie Fitch
15. Birthplace Balto - Md.

16 (a) Informant Fred A. Heim
(b) Address 4112 La Salle ave

17 (a) Burial (b) Date thereof 6/21/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road

18 (a) Funeral director Howard N. Blight Jr.
(b) Address 4914 Belair Road

19 (a) (b)
(Date filed by Registrar) Registrar

JUN 18 1947 Washington Nathaniel, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1947, at 2:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on Jun e 1 8 A. 19

Immediate cause of death	Duration
Congestive failure due to	
Infarction of	
myocardium	
Due to Arteriosclerotic heart disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bernard Burgun M.D.
Address Sinai Hosp. Date signed 6/18/47

Howard J. Nunn M.D.
X (over)

G52697

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G52697 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D o A
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Rural — Pikesville Rd
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1 Irving Place
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME John E. Sullivan

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mary M. Sullivan

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Aug 21-1884

8. AGE: Years 62 | Months 9 8 | Days 26 25 | If less than one day ____hr. ____min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Balto. Co. Md.

FATHER
12. Name George W. Sullivan
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden Name Elizabeth C. Bankard
15. Birthplace Carroll Co. Md.

16 (a) Informant Mary M. Sullivan
(b) Address 1 Irving place. Pikesville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 19-37 (Month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave. Balto. Md.

18 (a) Funeral director Frank H. Newell
(b) Address Pikesville, Maryland

JUN 18 1937 Huntington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/15 1937 2:25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to Hypertension - Arteriosclerotic C.V. disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur? ____
(c) Did injury occur at home, on farm, industrial place, in public place? ____ While at work? ____
(d) Means of injury ____

23. Signature C. P. Sobanske M.D.
Medical Examiner.
Date signed 6/16/37

G52698 BALTIMORE CITY HEALTH DEPARTMENT G52698

CERTIFICATE OF DEATH 47

Registered No. 517

Every item of information should be carefully supplied. The cause is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 602 N. Caroline St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 602 N. Caroline St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Roles
3 (b) If veteran, name war
3 (c) Social Security Account No. 219-05-0432

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced widowed

6 (b) Name of husband or wife Ida Roles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-31-1880

8. AGE: Years 66 | Months 9 | Days 16 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation laborer
11. Industry or business

FATHER 12. Name
13. Birthplace Unknown

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Evelyn Butcher (daughter)
(b) Address 1515 E. Madison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 19-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Brooklyn Maryland

18 (a) Funeral director Mrs Ida Bailey
(b) Address 1421 E. Jefferson st

JUN 16 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-16 1947, at 9 45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-14 1947 to 6-16 1947 and that I last saw h[illegible] alive on 6-14 1947.

Immediate cause of death pulmonary malignancy (if lung)

Duration: recent

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Rayner Brown X

Address 1500 E. Madison St Date signed 6-18-47 M. D.

G52699 — BALTIMORE CITY HEALTH DEPARTMENT — G52699 Registered No.

CM 111489

CERTIFICATE OF DEATH

X 13B

PLEASE WRITE PLAINLY. Every item of information should be carefully supplied. The use of UNFADING INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Hrs. 45 M 5
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 409 Riverside Drive Z21
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Phillips, Winnie Davis

3 (b) If veteran, name war ~ | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife John
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6 - 1910

8. AGE: Years	Months	Days	If less than one day
37	0	9 11	hr. min.

9. Birthplace N.C.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John W. Yow
13. Birthplace N.C.

MOTHER
14. Maiden Name Leola King
15. Birthplace N.C.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 20 47 (month) (day) (year)
(c) Cemetery or crematory Asheboro
Location Asheboro, N.C.

18 (a) Funeral director Lilly & Zeiler, Inc.
(b) Address 403 S. Wolfe, St. Balto. Md.

JUN 18 1947 (Date received by Registrar) Huntington Williams (Registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June -17- 1947, at 4.00A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 19 47 to June -17 19 47 and that I last saw her alive on June 17 19 47

Immediate cause of death: Subarachnoid Hemorrhage — Duration: 5 Hrs.
Due to: unknown cause
Due to:
Other Conditions: ① Pulmonary tuberculosis, active ② Tuberculous meningitis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edwin C. Evans, M.D.
Address Balto. City Hosp. Date signed 6-18-1947

83a

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item or information should be carefully supplied. The

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G52700 / 170 C

Registered No. G52700

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address EASTERN AVE.
(c) Hospital or institution: Balto City Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1925 E. PRATT ST. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Georgia Nelson

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	MARRIED

6 (b) Name of husband or wife KENNY NELSON
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1915

8. AGE: Years	Months	Days	If less than one day
32			hr. min.

9. Birthplace VIRGINIA (Town, county, and state)
10. Usual Occupation ?
11. Industry or business CHRISTMAS BALL FACTY.

FATHER
12. Name CHARLES NELSON
13. Birthplace UNKNOWN

MOTHER
14. Maiden Name ELLA WHITT
15. Birthplace UNKNOWN

16 (a) Informant KENNY NELSON - HUSBAND
(b) Address 1925 E. PRATT ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6-21-1947 (month) (day) (year)
(c) Cemetery or crematory BLUEFIELD
Location BLUEFIELD, W. VA.

18 (a) Funeral director Tilley & Zeiler Inc
(b) Address 403 S. WOLFE ST.

19 (a) 6-18-1947 (Date received by registrar) (b) Huntington Williams M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-14-1947, at 5:35 P.M.

21. I certify that I took charge of the remains described above, held an Insp & Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Skull

Due to

Other Conditions Bilat. Compound Fracture Femurs & Tibiae
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6/4/47 at Central Std. 7:30 P.M.
(b) Where did injury occur? Pulaski Highway & Summit Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck by auto

23. Signature [illegible] M.D. (Medical Examiner)
Date signed 6/4/47.

Use Typewriter or Indelible Pencil. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 8Ba

Registered No. G52701

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1902 Longwood St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1902 N. Longwood St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA MAY McCLURE

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1886

8. AGE: Years	Months	Days	If less than one day
60	11	6	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Packer
11. Industry or business Read Drug & Chem. Co.

FATHER
12. Name Charles P. McClure
13. Birthplace Balto.

MOTHER
14. Maiden Name Nannie M. Harford
15. Birthplace Md.

16 (a) Informant Mrs. Helen E. Rotan
(b) Address 1902 N. Longwood St.

17 (a) Burial (b) Date thereof 6/21/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Loudon Park
Location Balto. Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves Balto. 17, Md

19 (a) JUN 18 1947 (b) Received by registrar Washington Nathaniel, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1947, at 12 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 29 1947 to June 18 1947 and that I last saw h-er alive on June 17 1947.

Immediate cause of death	Duration
Due to Cerebral Apoplexy.	10 days.
Due to Hypertension and Arteriosclerosis.	Few yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature M Baumgartner M.D.
Address 2200 Jarrison Blvd Date signed 6/18/47

G52702
511222.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X ✓ G52702 Registered No. 157E

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Ala. (b) County.....
(c) City or town Birmingham (If outside city or town limits, write RURAL and give town)
(d) Street No. 224 S. Park Road. (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME William Rogan Jr.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 7-28-46

8. AGE: Years	Months	Days	If less than one day
	10	22	....hr. ....min.

9. Birthplace Ill. (Town, county, and state)
10. Usual Occupation.....
11. Industry or business

FATHER
12. Name William Rogan
13. Birthplace Ala.

MOTHER
14. Maiden Name Margie Reffee
15. Birthplace Ill

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 21, 1947 (month) (day) (year)
(c) Cemetery or crematory Millport
Location Millport Ala

18 (a) Funeral director Harry H. Lutzke
(b) Address 401 Edmondson Ave

19 (a)..... (b)..... (Date received by registrar) Registrar

JUN 18 1947

VS 150

MEDICAL CERTIFICATION

A

20. DATE OF DEATH June 18 1947, at 3.00 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 14 1947, to June 18 1947, and that I last saw him alive on June 18 1947.

	Duration
Immediate cause of death RESPIRATORY FAILURE	
Due to PULMONARY EDEMA	
Due to PULMONARY ARTERY AORTIC ANASTAMOSIS FOR	
Other Conditions CONG. HRT. DISEASE & TETRALOGY OF FALLOT	

(Include pregnancy within 3 months of death)
Date of operation 6/16/47
Major findings of operation.....
of autopsy.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature W. A. Brennan M. D.
Address Johns Hopkins Hospital Date signed 6/18/47 M. D.
Harriet Lane Home

G52703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √117a

G52703 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1819 Lemmon St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Thorpe

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M Separated

6 (b) Name of husband or wife Blanche E. Thorpe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/9/1888

8. AGE: Years	Months	Days	If less than one day
58	8	8	hr. min.

9. Birthplace Balto., Md
(Town, county, and state)
10. Usual Occupation Bar Tender
11. Industry or business

FATHER
12. Name George Thorpe
13. Birthplace Scotland

MOTHER
14. Maiden Name Elizabeth Mullen
15. Birthplace Ireland

16 (a) Informant Blanche E. Thorpe
(b) Address 819 Lemmon St

17 (a) Burial (b) Date thereof 6/20/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 JUN 19 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/12 1947 to 6/17 1947 and that I last saw h[illegible] alive on 6/17 1947.

Immediate cause of death	Duration
Cerebral Anemia	
Due to Gastric Hemorrhage	
Due to GASTRIC ULCER	
Other Conditions ARTERIOSCLEROSIS.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy Office Record Verified

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Wills Jr. M.D.
Address Mercy Hosp. Date signed 6/17/47

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write

052704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 052704

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Mercy Hospital 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 435 E. Preston St.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Jessie May Thompson

3 (b) If veteran, name war: W

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) ~~Single, married, widowed, or~~ divorced.
Female	White	Divorced

6 (b) Name of husband ~~or wife~~ Morgan K. Thompson

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 25th 1879

8. AGE: Years	Months	Days	If less than one day
68	0	22	..... hr. ..... min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name Edgar T. Linder
13. Birthplace England

MOTHER
14. Maiden Name Unknown
15. Birthplace Pa.

16 (a) Informant Chas. M. Thompson
(b) Address 211 Wilhelm St

17 (a) Burial (b) Date thereof 6/21/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Mountain View
Location Howard Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address St. Paul St.

19 (a) JUN 19 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1947, at 6:30 AM

21. I certify that I took charge of the remains described above, held an Insp. & Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute congestive heart failure

Due to Hypertensive Cardio-vascular disease

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☒ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Carl A. Royer M.D.
Medical Examiner.
Date signed 6-18-47

G52705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G52705

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1506 N. Montford
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1506 N. Montford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie E. Heiss

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife William A. Heiss
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20 1868

8. AGE: Years	Months	Days	If less than one day
78	11	28	hr. min.

9. Birthplace Baltimore Md. (town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name George Betz
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Anna Nolen
15. Birthplace Balto. Md.

16 (a) Informant Amelia Breiter
(b) Address 1205 N. Milton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-20-47 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location North Ave.

18 (a) Funeral director John J. Nulty Inc.
(b) Address 2435 E. Oliver St.

JUN 19 1947 (Date Rec'd by Registrar) (b) Huntington for Nulty Inc. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-17 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-1 1947 to 6-17 1947 and that I last saw h[illegible] alive on 6/16/1947

Immediate cause of death — Duration
Myocardiac 6 hrs
Due to Cardiac
Due to Vascular
Other Conditions Arterial
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Fred Rupprecht M. D.
Address 1611 N. Patterson Park Ave. Date signed 6-19-1947

G52706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 157E

Registered No. G52706

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Baumgardner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-30-47

8. AGE: Years	Months	Days	If less than one day
		18	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Joseph Baumgardner
13. Birthplace Va.

MOTHER 14. Maiden Name Elsie Hargtm
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 20-47 (month) (day) (year)
(c) Cemetery or crematory Bel Air Burial Park
Location Bel Air Md.

18 (a) Funeral director G. E. Arthur
(b) Address Fork Md.

19 JUN 19 1947 (Date rec'd by reg.) Harlington Williams M.D. (Registrar)

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1947 at 11.50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1947, to June 17 1947, and that I last saw him alive on June 17 1947.

	Duration
Immediate cause of death CARDIO-RESPIR-ATORY FAILURE	
Due to (1) TOXEMIA - FROM SPECIFIC DYSENTERY	
Due to (2) ? SEPTICEMIA.	
(3) ? CONG. HRT. DISEASE	
Other Conditions CYANOTIC TYPE	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. A. Spencer M.D.
Address Johns Hopkins Date signed 6/18/47

Harriet Lane Home

G52707

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. G52707

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette and Calhoun
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 209 Rosewood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva KINCAID

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife G. Clinton Kincaid

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) 18 Nov 02

8. AGE: Years 44 45 | Months 6 | Days 29 | If less than one day ... hr. ... min.

9. Birthplace Vt.
(Town, county, and state)

10. Usual Occupation H.W.

11. Industry or business HOME

FATHER
12. Name Felix La Bell
13. Birthplace Vt

MOTHER
14. Maiden Name Clara Dennis
15. Birthplace Vt.

16 (a) Informant J. Clinton Kincaid
(b) Address 209 Rosewood ave

17 (a) Burial (b) Date thereof 6/21/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary
Location Burlington Vt

18 (a) Funeral director Ezra I MacNabb
(b) Address Catonsville Md

JUN 19 1947 (b) Kunting for Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 Jun 1947, at 8 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7 Jun 1947 to 17 Jun 1947 and that I last saw her alive on 17 Jun 1947

Immediate cause of death Bronchopneumonia, confluent — Duration

Due to metastases to lungs

Due to carcinoma, tail of pancreas

Other Conditions aortic atherosclerosis, moderate
(Include pregnancy within 3 months of death)

Date of operation 16 Jun 47

Major findings of operation: abdominal carcinosis

of autopsy: carcinoma & metastases

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. Morton Krafft
Address Franklin Square Hosp. Date signed 6/17/47 M. D.

X

G52708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G52708

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street-address 33rd & Calvert
(c) Hospital or institution: Union Mem. Hospital 9-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt City
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 916 E Monument Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ELLA MARY GROSS

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Charles J. Gross dead
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Nov 11, 1863

8. AGE: Years	Months	Days	If less than one day
83	07	7	____ hr. ____ min.

9. Birthplace Balt Md (Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business

FATHER
12. Name George Kleinly
13. Birthplace Md

MOTHER
14. Maiden Name Emma Rachel Fryer
15. Birthplace Md

16 (a) Informant Mrs John B Young
(b) Address 916 E Northave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/21/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park Cem.
Location Woodlawn, MD.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 19 1947 (Date rec'd by registrar) Tuntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 June 1947, at 1:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1947 to June 12 1947, and that I last saw her alive on June 12 1947.

Immediate cause of death	Duration
Carcinoma fracture	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address Union Mem. Hospital Date signed 6-16-47

X

G52709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44B

G52709 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 days
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 648 Dunbarton Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Lola Mary Stevenson MARY E. STEVENSON

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Wid.

6 (b) Name of husband or ~~wife~~ G. Melville Stevenson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21, 1886

8. AGE: Years	Months	Days	If less than one day
60	10	27	hr. min.

9. Birthplace Wilmington, Del.
(Town, county, and state)
10. Usual Occupation Hwf.
11. Industry or business

FATHER
12. Name Webster Richardson
13. Birthplace ? Wilmington Del

MOTHER
14. Maiden Name Mary Davis
15. Birthplace ? Preston Md.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 6/21/47 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Cambridge Cem.
Location Cambridge, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Baltimore 17, Md.

19 (a) Date received by Registrar JUN 20 1947 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1947, at 2:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 13 1947 to June 17 1947 and that I last saw h~~im~~er alive on June 17 1947.

Immediate cause of death Malnutrition and inanition — Duration

Due to Hodgkins disease — 4 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. Monroe M. D.
Address U S Marine Hosp Date signed 6-17-47

X

C52710 John Trockenbrot. BALTIMORE CITY HEALTH DEPARTMENT Registered No. C52710
1a

CERTIFICATE OF DEATH 13a

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 310 N. Paca St.
(c) Hospital or institution: 4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 310 N. Paca St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN TROCKENBROT

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widower

6 (b) Name of husband or wife: Emma Baltz Trockenbrot
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1864

8. AGE: Years 83 | Months 0 | Days 11 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Manufacturer Jeweler
11. Industry or business Self

FATHER
12. Name Peter Trockenbrot
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Haberkam
15. Birthplace Germany

16 (a) Informant Mrs. Conrad Zieget
(b) Address 2402 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/21/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 19 1947 (b) Huntington Williams, M.D. Registrar
(Date received by Registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18th 1947, at 11 25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/29 1947, to 6/18 1947, and that I last saw him alive on 6/17/47 1947.

Immediate cause of death	Duration
Uraemia	48 hrs
Due to Chr. Nephritis	3 mos.
Due to Arterio sclerosis	2 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Rinderknecht M.D.
Address 1136 Pipkin Jones St Date signed 11/10/47

G52711 BC# 19753

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 157M

Registered No. G52711

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 3631 Liberty Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Laurence Paul Klumpus

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-1-47

8. AGE: Years | Months | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Herman Klumpus
13. Birthplace Balto Md

MOTHER
14. Maiden Name Rosalie Ehrlich
15. Birthplace Balto Md

16 (a) Informant Herman Klumpus
(b) Address 3631 Liberty Hgts ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-19-47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Young Men
Location Windsor Mill Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 1499 E Balto St

19 (a) JUN 19 1947 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/18 1947, at 2:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/18 1947 to 6/18 1947, and that I last saw him alive on 6/18 1947

Immediate cause of death	Duration
Heart Failure	
Due to: Septicemia	
Due to: Infection left 1st & 2nd toes	
Other Conditions: Splenomegaly	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Autopsy - Grafting found in groin area, Microscopic not obtained yet

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene O. Goldstein M. D.
Address Sinai Hospital Date signed 6/18/47

VS 150

X

G52712

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44B

Registered No. G52712

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4252 Pimlico Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-13
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4252 Pimlico Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rose Korsover

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years 58 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Moses
13. Birthplace Russia

MOTHER
14. Maiden Name Penn
15. Birthplace Russia

16 (a) Informant Joseph Korsover
(b) Address 4252 Pimlico Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-19-47 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Mt Carmel

18 (a) Funeral director Jack Lewis Inc
(b) Address 1459 E Baltimore St

19 JUN 19 1947 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19, 1947 at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1947, to June 19 1947, and that I last saw her alive on June 19 1947.

Immediate cause of death: Bronchopneumonia — Duration: 1 day

Due to:

Due to:

Other Conditions: Hodgkins Disease — 12 yrs.

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sheldon Ira Wolfe M. D.

Address 944 N. Milton St Date signed 6/19/47

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Q52713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. Q52713

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wynnewood St. & Rutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-12
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3435 Pk. Hgts. Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Gorlitz

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	White	married

6 (b) Name of husband or wife Philip Gorlitz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph —
13. Birthplace Russia

MOTHER
14. Maiden Name Rosie —
15. Birthplace Russia

16 (a) Informant Philip Gorlitz
(b) Address 3435 Pk. Hgts. Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-19-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Orange Grove

18 (a) Funeral director Jos. Feuss Inc
(b) Address 1429 E. Balto. St.

19 (a) JUN 19 1947 (Month and day registered) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1947 at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/4 1947 to 6/16 1947 and that I last saw h— alive on 6/17 1947.

Immediate cause of death Pulmonary embolism ?
Due to
Due to
Other Conditions Arteriosclerosis of
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M.D.
Address Date signed M.D.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No. G52714

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 0 21
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2092 (T.) Penn Street (If rural give location)
309 PENN St.
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Cheatham

3 (b) If veteran, name war

3 (c) Social Security Account No. 247-05-7028

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Irene Cheatham

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years: 46 | Months | Days | If less than one day: hr. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation: Lather.

11. Industry or business

FATHER
12. Name: Horace Cheatham
13. Birthplace: Va

MOTHER
14. Maiden Name: unknown
15. Birthplace: Va

16 (a) Informant: Irene Cheatham
(b) Address: 1709 Riggs Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/20/47 (month) (day) (year)
(c) Cemetery or crematory: Unity Graveyard
Location: Lynchburg, Va.

18 (a) Funeral director: Metropolitan Funeral Home
(b) Address: 927 N. Mount St.

19 (a) JUN 19 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1947, at 9:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Due to Acute Congestive Heart Failure

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at A.M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Reyburn M.D.
Medical Examiner.

Date signed 6-17-47

G52715 BERGMAN

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 ✓

Registered No. G52715

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2901 E Jefferson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-
(e) Length of stay in Baltimore (yrs., mos., or days) 60

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2901 E Jefferson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Bergman

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: George Bergman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 14 1854

8. AGE: Years 92 | Months 6 | Days 3 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Simon Goeller
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant Mrs Jennie Voith
(b) Address 2901 E Jefferson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 20 47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director W J Herr & Son
(b) Address 2001 Bentalou ave

19 JUN 19 1947 (Date filed by Registrar) (b) Livingston Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1947 at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947 to June 17 1947 and that I last saw alive on June 14 1947

Immediate cause of death Hypostatic pneumonia — Duration

Due to Cardiac decompensation — Duration

Due to Senile debility — Duration

Other Conditions Arteriosclerosis — Duration

(Include pregnancy within three months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Fred Dunsick M.D.

Address 600 N Milton Ave Balto 17 Md

VS 150

G52716

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G52716

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3202 Clarence Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3202 Clarence Aven (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LOUIS C. GLANTZ

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. NONE

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: Mamie T. Glantz
6 (c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) Mar. 9, 1884

8. AGE: Years	Months	Days	If less than one day
63	3	8	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business City of Baltimore

FATHER
12. Name Henry Glantz
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Theresa Krock
15. Birthplace Germany

16 (a) Informant Mrs. Mamie T. Glantz
(b) Address 3202 Clarence Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/20/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) JUN 19 1947 (Date rec'd by registrar) (b) Huntington Wellington M.D. Registrar

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH June 17 1947, at 11.25 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1946 to June 17 1947 and that I last saw h[illegible] alive on 6-17 1947

Immediate cause of death: Hypertensive cardio-vascular disease — Duration: 5 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Owen Moore M. D.
Address 3106 Belair Rd Date signed 6-18-47

G52717

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121B

Registered No. G52717

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 620 E. 38th. Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 620 E. 38th. Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE LOUIS SCHUCKLE

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 216-10-6559

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Irene E. (Johnson) Schuckle

6 (c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.) May 27, 1882

8. AGE: Years 65 | Months 0 | Days 21 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business Balto. Feed & Grain

FATHER
12. Name Geroge L. Schuckle
13. Birthplace Penna.

MOTHER
14. Maiden Name Annie Gurnd
15. Birthplace ?

16 (a) Informant Mrs. Irene E. Schuckle
(b) Address 620 E. 38th. Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/21/47 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

19 (c) JUN 19 1947 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION PM

20. DATE OF DEATH June 17 1947, 8.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 1947 to June 17 1947 and that I last saw him alive on June 17, 1947.

Immediate cause of death	Duration
Chronic Hypertrophic Myocarditis	?
Due to Chronic Nephritis	
Hypertrophic Arthritis	
Due to Hemorrhagic Purpura	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan Janney M.D.

Address 7101 Harford Rd. Date signed 6/18/47

VS 150

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

87E

Registered No. G52718

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 27-14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1018 Providence St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clinton Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	B	Married

6 (b) Name of husband or wife Eliza

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3, 1901

8. AGE: Years	Months	Days	If less than one day
46	11	14	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER
12. Name Clarence Johnson
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Rachel Flores
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Eliza A. Johnson
(b) Address 1018 Providence St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 22, 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George A. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) JUN 19 1947 (Date rec'd by registrar) (Huntington Williams, M.D.) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/17 1947, at 1.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-6-47 19 , to 6-17 1947 and that I last saw him alive on 6-17 1947.

Immediate cause of death Cerebral Thrombosis — Duration 7 days

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 6-11-47

Major findings of operation: MENINGO-ENCEPHALOGRAM - Normal Int. Hydrocephalus

of autopsy: HYDRO. CEPHALUS

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John C. Morrison M. D.
Address Univ. Hosp. Date signed 6/17/47

X

G52719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G52719

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1312 Division St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Earl Lee

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-01-1206

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Hilda O.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1897

8. AGE: Years	Months	Days	If less than one day
49	8	16	hr. min.

9. Birthplace Washington D.C. (Town, county, and state)
10. Usual Occupation Janitor
11. Industry or business

FATHER
12. Name Wm McKinley Lee
13. Birthplace Wash. D.C.

MOTHER
14. Maiden Name Margaret Green
15. Birthplace Wash. D.C.

16 (a) Informant Mrs. Hilda O. Lee
(b) Address 1312 Division St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 22, 1942 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. George A. Holland
(b) Address 1631 David Hill Ave. Huntington Williamsport, Md.

19 (a) JUN 19 1942 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/16 1942, at 11:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/13 1942 to 6/16 1942, and that I last saw h[illegible] alive on 6/16 1942.

Immediate cause of death Uremia — Duration ?

Due to Hypertensive Cardio-Vascular Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature I. C. Welcome, M.D.
Address 1131 Harlem Ave. Date signed 6/17/42

VS 150

52720

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E ✓

G52720 Registered No. 3698

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1130 Mosher St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1130 Mosher St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Thompson Clark

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife Carter Clark
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 24, 1879

8. AGE: Years	Months	Days	If less than one day
67	7	4	hr. min.

9. Birthplace Gloucester Co. Va (Town, county, and state)
10. Usual Occupation Home work
11. Industry or business own home

FATHER:
12. Name Joseph Gardner
13. Birthplace Virginia

MOTHER:
14. Maiden Name Fannie Willis
15. Birthplace Virginia

16 (a) Informant Mrs. Julia Clark Thompson
(b) Address 1130 W. Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-19-1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Chas. George est. Holland
(b) Address 1609 North Hill Ave.

19 (a) JUN 19 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-16-1947, at 6:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-1-1947, to 6-16-1947, and that I last saw her alive on 6-14-1947.

Immediate cause of death	Duration
Myocarditis	16 days
Due to Coronary arteriosclerosis	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 1029 N. Stricker St. Date signed 6-19-1947

X

G52721

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 7698 G52721

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 533 Gold St
(c) Hospital or institution: 14

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 533 Gold St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Wm. Richardson Sr.

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 717-09-8402

4. Sex: M | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Hattie Richardson
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) 5-10-1875

8. AGE: Years 72 | Months 1 | Days 8 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Rail Road Porter

11. Industry or business Penna R.R.

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Hannah Penney
15. Birthplace Calvert Co. Md

16 (a) Informant Mrs. Hattie Richardson
(b) Address 533 Gold St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-21-47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director George E. Nelson
(b) Address 1303 Pressman St.

19 1947 JUN 19 (Date Rec'd by Registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-18-1947, at 1:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-15-1947 to 6-18-1947 and that I last saw him alive on 6-17-1947.

Immediate cause of death: Cerebral hemorrhage — Duration: 3

Due to: Hypertension Arteriosclerosis

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature Frank A. Saunders M. D.
Address 1029 Strieker St Date signed 6-18-47

VS 150

G52722

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95-C

G52722 Registered No.

Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) Daa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1236 E. Monument St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William HARDY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1913

8. AGE: Years 34 | Months | Days | If less than one day hr. min.

9. Birthplace Smithfield Va
(Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER
12. Name William Hardy
13. Birthplace Smithfield Va

MOTHER
14. Maiden Name Addie Hall
15. Birthplace Smithfield Va

16 (a) Informant Addie Hardy
(b) Address 1236 monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 19-1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cemet
Location Brooklyn Md

18 (a) Funeral director Thos O. Wilson
(b) Address 1000 Boynton Ave
(c) Huntington Williams, Md

JUN 19 1947 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 19 47 at 10 50 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute dilatation of heart

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner.

Date signed 6/16/47

X

BALTIMORE CITY HEALTH DEPARTMENT ✓ G52723
Registered No.

G52723

CERTIFICATE OF DEATH 55 E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3300 Calvert 13-1
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 weeks
(e) Length of stay in Baltimore (yrs., mos., or days) 73 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Temple Gardens Apts., Balt.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Amelia Lazarus

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband [redacted] Lazarus
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1873

8. AGE: Years 73 | Months 6 | Days 26 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Lady

11. Industry or business

FATHER
12. Name Samuel Hanford
13. Birthplace Balt. Md

MOTHER
14. Maiden Name Anne May
15. Birthplace New York

16 (a) Informant Mrs. Jerome Cohen
(b) Address 2736 Huntingtown Rd

17 (a) Burial (b) Date thereof 6/19/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Friends Lyn
Location Balto. Md.

18 (a) Funeral director Louis Sonnenkein & Son
(b) Address 1702 Eutaw Place

19 (a) Huntington Williams Mortuary
(Date rec'd by registrar)

JUN 19 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1947 at 4:47 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 2 1947 to June 17 1947 and that I last saw h[illegible] alive on June 17 1947

Immediate cause of death — Duration

Cardiac Failure

Due to

Due to

Other Conditions Carcinoma W. Th metastases primary site undetermined.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Carcinoma.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Peter Randall M. D.

Address [redacted] Date signed

Hosp. x 6-17-47

G52724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

G52724 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2301
(c) Hospital or institution: South Baltimore Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs.) mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 140 W. Cross St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph A. Dunn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/7/1929

8. AGE: Years	Months	Days	If less than one day
17	6	10	hr. min.

9. Birthplace Augustus Ga
(Town, county, and state)

10. Usual Occupation L

11. Industry or business

FATHER
12. Name James Dunn
13. Birthplace Ga

MOTHER
14. Maiden Name Annie Stevens
15. Birthplace Ga

16 (a) Informant Annie Dunn (M)
(b) Address 140 W Cross St

17 (a) Burial (b) Date thereof 6-22-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location B & O Road

18 (a) Funeral director Isaiah L. Brown Sons
(b) Address 108 N Montgomery St

JUN 19 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1947, at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-17-47 at 1:30 P M(?) 25/6
(b) Where did injury occur? Patapsco River Masonville
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? no
(d) Means of injury Drowned while swimming

23. Signature Carl L. Reyle M.D.
Medical Examiner.

Date signed 6-18-47

VS 191

Physicians: please write the exact age is especially important. The information should be carefully supplied. The causes of death clearly and legibly.

Jessie Cruse

BALTIMORE CITY HEALTH DEPARTMENT ✓ G52725

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St. 22
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 132 Hill Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jessie Cruse Cruse

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Mary Cruse
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace Alabama (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name Not Known
13. Birthplace

MOTHER 14. Maiden Name Not Known
15. Birthplace

16 (a) Informant Mary Cruse
(b) Address 802 Leadenhall St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/21/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto. Co. Md

18 (a) Funeral director Samuel L Brown Sons
(b) Address 1014 W Monument St.

19 (a) 1947 (Date rec'd by registrar) (b) Registrar for Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1947 at 12:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1947 to June 18 1947, and that I last saw h alive on June 18 1947

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to arteriosclerotic & hypertensive heart disease	
Due to generalized Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature [signature]
Address 42 Light St Date signed 6-18-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G52726 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6-
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. o. A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 4
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1800 E. Fayette st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ursula Parker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1906

8. AGE: Years 41 | Months | Days | If less than one day hr. min.

9. Birthplace Pearson Co N.C.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Daniel Woodley
13. Birthplace Pearson Co N.C.

MOTHER
14. Maiden Name Lindsay Lawson
15. Birthplace Pearson Co N.C.

16 (a) Informant Fannie Mitchell
(b) Address 204 N. Ayon St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 20-1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cemetery
Location Brooklyn Md

18 (a) Funeral director Elroy D. Wilson
(b) Address 1002 Baltimore Ave

19 (a) JUN 19 1947 (Date rec'd by registrar) Registrar for Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-15-1947, at 2:15 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Due to Hypertensive Cardio-vascular disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earle Royer M.D.
Medical Examiner

Date signed 6-16-47

VS 151

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G527727

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G527727

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Redwood
(c) Hospital or institution: University Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4od.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3309 Payne St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME CALVIN LOCKNER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Georgiana

6 (c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 79 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Peddler

11. Industry or business

FATHER
12. Name Jake Lockner
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine Lehigh
15. Birthplace Md.

16 (a) Informant wife
(b) Address same

17 (a) Burial (b) Date thereof 6-21-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lorraine
Location Balto

18 (a) Funeral director Frank H. Seitz
(b) 1436 Light St.

19 (a) JUN 19 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-18 1947 at 1:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-22 1947 to 6-18 1947
and that I last saw him alive on 6-17 1947.

Immediate cause of death Cerebral Embolism — Duration

Due to Auricular Fibrillation with mural thrombi

Due to and peripheral arterial embolism

Other Conditions arteriosclerotic C-V Disease, mild uremia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at: M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Workman

Address Md. Gen. Hosp. Date signed 6-18-47 M. D.

J. G. WORKMAN, M.D.

VS 150

G52728

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G52728

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16-
(c) Hospital or institution: Md. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1829 Raynor Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daisy Bonner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex 7

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Edward Bonner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 7 - 1881

8. AGE: Years 66 | Months 5 | Days 11 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER
12. Name Basil Sheffield
13. Birthplace Unknown

MOTHER
14. Maiden Name Catherine Hess
15. Birthplace Unknown

16 (a) Informant Jane Dertie Fleetwood
(b) Address 1010 Mc. Keon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 21 48 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore Md.

18 (a) Funeral director Magnus Co. Byers
(b) Address 1600 W. North Ave

19 (a) JUN 19 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-18-1947 at 2 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to last death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Carcinoma of large intestine. (sigmoid)

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard A. Mercer M.D.
Medical Examiner.
Date signed 6-18-47

correct age is especially important. Physicians: please write the ... Every item of information should be carefully supplied. The ... CAREFULLY. USE INDELIBLE INK. Every ... the causes of death clearly and legibly.

G52729

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 65a

Registered No. G52729

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3116 White Ave
(c) Hospital or institution: Bon Secours Hosp. 27-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 37

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3116 WHITE AVE
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. MARGARET DEFORD

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Harold C DeFord

6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) Sept 30 1909

8. AGE: Years 37 | Months 8 | Days 18 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER 12. Name John F Tress
13. Birthplace Baltimore.

MOTHER 14. Maiden Name Mary E Dennis
15. Birthplace Baltimore

16 (a) Informant Harold C. DeFord
(b) Address 3116 W Lete Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 21. (month) (day) (year)
(c) Cemetery or crematory Loudon Park Balto Cem
Location City

18 (a) Funeral director Wilkie Funeral Home
(b) Address 2008 Orleans St

19 JUN 19 1947 (b) Registrar

VS 184

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1947 at 1.45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1947 to June 18 1947, and that I last saw her alive on June 18 1947.

Immediate cause of death	Duration
CARDIO-RESPIRATORY FAILURE	2 HRS.
Due to (CRISIS OF) ADDISON'S DISEASE	10+ MOS.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Atrophy of Adrenal Glands

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. H. Smith J.
Address Bon Secours Hosp. Date signed 6/18/47 (M. D.)

X

652730 Harris

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 652730

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 415 E Preston St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 415 E Preston St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Somerville Young

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-10-7961

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Margt. Jewell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Balto Co. (Town, county, and state)
10. Usual Occupation Sanitation Dept
11. Industry or business Clerk
FATHER 12. Name Daniel Young
13. Birthplace Balto Co.,
MOTHER 14. Maiden Name ? Harris
15. Birthplace Balto Co
16 (a) Informant Mrs. Young
(b) Address 415 E. Preston St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 21, 1947 (month) (day) (year)
(c) Cemetery or crematory Carlton Wood
Location Baltimore
18 (a) Funeral director Rita Weisfeld
(b) Address 900 East Biddle St
19 (a) JUN 19 1947 (Date rec'd by Local Reg.) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1947, at 9:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1947 to June 18 1947, and that I last saw him alive on June 17 1947.

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to Interna Cardiovasc. disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph Friedman M. D.
Address 1206 E Preston Date signed June 19, 1947

Dr Bloom

X

G52794 Vaus

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G52731

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 78

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1228 E. North ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Edward W. Griebel

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Margaret A Smith
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 31, 1869
8. AGE: Years 78 | Months 2 | Days 18 | If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Grocer

FATHER
12. Name John N. Griebel
13. Birthplace Germany

MOTHER
14. Maiden Name Elis. Reed
15. Birthplace Germany

16 (a) Informant Edw C. Griebel
(b) Address 1228 E. North Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 21, 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore
18 (a) Funeral director Rife Wredefeld
(b) Address 909 E. Biddle St.
19 (a) JUN 19 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/18/1947 at 5:20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/17 1947 to 6/18 1947. and that I last saw h/m alive on 6/17 1947

Immediate cause of death: Cardiac Failure — Duration
Due to: Coronary arteriosclerosis
Due to: Chronic nephritis
Other Conditions: Secondary anemia

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard H. Young, M.D.
Address St. Joseph's Hosp. Date signed 6/18/47

VS 130

G52732

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G52732

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3808 Fear Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3808 Fear Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM H. BELL

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Katie Murray Bell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 27, 1871

8. AGE: Years	Months	Days	If less than one day
76	3	19	hr. min.

9. Birthplace Balto. Co., Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Gardner- general

FATHER
12. Name Samuel Bell
13. Birthplace Maryland

MOTHER
14. Maiden Name Caroline Carter
15. Birthplace Maryland

16 (a) Informant Edward A. Bell
(b) Address 5035 Reisterstown Rd., Balto., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 20, 1947 (month) (day) (year)
(c) Cemetery or crematory Sater's Cemetery
Location Brooklandville, Balto. Co., Md.

18 (a) Funeral director John Burns Sons
(b) Address Towson, Maryland

19 (a) JUN 19 1947 (Date received by Registrar) Huntingtown Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18, 1947, at 4:15A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1, 1947 to June 18 1947, and that I last saw h[illegible] alive on June 18 1947

Immediate cause of death	Duration
Cardiac Failure	2 days
Due to Arteriosclerotic Heart disease + Coronary sclerosis	2 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Manuel Levin M. D.
Address 4818 Reisterstown Rd Date signed June 19/47

G52733 BALTIMORE CITY HEALTH DEPARTMENT G52733

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1009 Bonaparte Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1009 Bonaparte Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vincenzo Annarino

3 (b) If veteran, name war: none
3 (c) Social Security Account No.:

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of ~~husband~~ or wife: late Annunziata
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 27 1873

8. AGE: Years 74 | Months 4 | Days 22 | If less than one day: hr. min.

9. Birthplace Fermini Imerese Italy
(Town, county, and state)
10. Usual Occupation Fruit Dealers
11. Industry or business Self

FATHER
12. Name Agostino Annarino
13. Birthplace Italy

MOTHER
14. Maiden Name Rosa Palmisano
15. Birthplace Italy

16 (a) Informant Joe Annarino (Son)
(b) Address 1009 Bonaparte Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 20/47 (month) (day) (year)
(c) Cemetery or crematory XXXXXXXXX Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Frank Della Rose
(b) Address 52 N. Morley St.

19 (a) JUN 19 1947 (b) [illegible]
(Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1947, at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1946 to June 18 1947, and that I last saw ~~him~~ alive on June 15 1947.

Immediate cause of death	Duration
Hypertensive Cardiovascular disease	
Due to Chronic Myocarditis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Brolle M. D.
Address 1331 Eutaw Pl. Date signed 6-19-47

G52734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G52734

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6116 Sefton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 74 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6116 Sefton Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barney Rosowsky

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife: Frances
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER 12. Name	Harry
FATHER 13. Birthplace	Russia
MOTHER 14. Maiden Name	Anna
MOTHER 15. Birthplace	Russia

16 (a) Informant Harry Ross
(b) Address 6116 Sefton Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-19-47 (month) (day) (year)
(c) Cemetery or crematory Location New Haven Corp
18 (a) Funeral director Jack Lewis Inc
(b) Address 1429 E Balto St
19 JUN 20 1947 Huntington Williams, M.D. Address

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1947, at 6 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1947, to June 9 1947, and that I last saw h[illegible] alive on June 9th 1947.

Immediate cause of death: Carcinoma Stomach — Duration

Due to

Due to

Other Conditions: Mamed cachexia and anemia (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Marrs A Jones M. D.
Address 118 Biscayne Ave Date signed 6/19/47

VS 150

G52735

CWK-110984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

126

Registered No. G52735

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 79- 6- 0-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 249 S. Highland Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susan Lavinia Volkman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Henry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18-1867

8. AGE: Years	Months	Days	If less than one day
79	6	0	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Richard Westerbelt
13. Birthplace New Jersey

MOTHER
14. Maiden Name Mary ?
15. Birthplace Pennsylvania

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/22/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Williams Cook Inc
(b) 3411 Pont St

19 (a) JUN 20 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH June 18 1947 at 7:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 27 1947, to June 18 1947, and that I last saw h. alive on June 18 1947

Immediate cause of death Cholecystitis, chronic, & cholelithiasis — Duration

Due to

Due to

Other Conditions Hypertensive Cardio-vascular disease.
(Include pregnancy within 3 months of death)

Date of operation 6-18-47

Major findings of operation: Adhesions

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marvin M. Lacy, M.D.
M. D.
Address Baltimore City Hosp. Date signed 6-19-47

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G52736
Registered No.

1. PLACE OF DEATH: DOA
(a) Baltimore City, Maryland
(b) Street address 2800 N. Calvert St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2800 N. Calvert St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia Cashmeyer (CASHMYER)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1870

8. AGE: Years	Months	Days	If less than one day
77	1	6	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation School Teacher
11. Industry or business Retired

FATHER
12. Name Philip Cashmyer
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Ann Mullen
15. Birthplace Maryland

16 (a) Informant Mrs. Virginia M. Miller
(b) Address 5104 Ivanhoe Avenue

17 (a) burial (b) Date thereof 6/20/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) JUN 20 1947
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/18 1947, at 6:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 6 Jun/47

VS 151

C52737 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. C52737

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1825 W. Lanvale Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1825 W. Lanvale Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William J. Kelly

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 215-09-5733

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Bessie Kelly
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 19, 1891

8. AGE: Years: 56 | Months: 2 | Days: 28 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Sta. Engineer
11. Industry or business: Comfy Manu. Co.

NAME OF FATHER
12. Name: Richard Kelly
13. Birthplace: Baltimore, Maryland

MAIDEN NAME OF MOTHER
14. Maiden Name: Mary Weaver
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Mrs. Bessie Kelly
(b) Address: 1825 W. Lanvale Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/21/47 (month) (day) (year)
(c) Cemetery or crematory: Baltimore
Location: Baltimore, Maryland

18 (a) Funeral director: Wm. Cook, Inc.
(b) Address: 1217 St. Paul Street

19 JUN 20 1947 (Date received by registrar) Thurlington Williamson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17, 1947, at 11:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1940 to June 17 1947 and that I last saw h alive on June 12 1947.

Immediate cause of death	Duration
Coronary Occlusion	3 min
Due to Arteriosclerosis & Chronic Myocarditis	2 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Egbert H. Mortimer Jr M. D.
Address 2706 St Paul Date signed 6/18/47

VS 150

G52738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered No. G52738

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 632 St. Ann's Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 632 St. Ann's Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick W. Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Married

6 (b) Name of husband or wife Camilla B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1876

8. AGE: Years	Months	Days	If less than one day
70	7	1	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Julius H. Brown
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Hausman
15. Birthplace Germany

16 (a) Informant Camilla Brown
(b) Address 632 St. Ann's Avenue

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 6/21/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) JUN 20 1947 (b) Registrar's signature Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19, 1947, at 2:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1947 to June 19 1947 and that I last saw h[illegible] alive on June 15 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	8 hrs
Due to Cerebral Arteriosclerosis	6 mos
Due to Generalized Arteriosclerosis	1 yr
Other Conditions Hypertension	1 year

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thurman T. Clark M. D.

Address 532 E 22nd St Date signed 6/19/47

G52739

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

Registered No. G52739

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT OR TYPEWRITE IN PENCIL OR INDELIBLE INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2da
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 642 W. Saratoga St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marion Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife Georgianna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 25, 1915

8. AGE: Years	Months	Days	If less than one day
32	4 2	24	hr. min.

9. Birthplace Sumter, S. C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Shipyard

FATHER
12. Name Golden Lee
13. Birthplace S. C.

MOTHER
14. Maiden Name Peoples
15. Birthplace S.C.

16 (a) Informant Georgianna Lee
(b) Address 642 W Saratoga St

17 (a) Burial (b) Date thereof 6-21-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lynchburg,
Location South Carolina

18 (a) Funeral director Adolphus Halstead
(b) Address 97 Edmondson Ave

19 JUN 20 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1947, at 2:45 PM

21. I certify that I took charge of the remains described above, held an Autopsy + Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Glomerular Nephritis
Chronic Hypocardial Degen.
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 6-19-47

G52710 BC#B-7957 G52710

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160 C

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. Monument St.
(c) Hospital or institution: Sinai Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 4 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto -5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1018 Hewitt Way
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Bawlus

3 (b) If veteran, name war

6 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	wht.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28, 1947

8. AGE: Years	Months	Days	If less than one day
NB.			4 hr. 9 min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Robert Bawlus

13. Birthplace Indiana

MOTHER 14. Maiden Name Minerva Wyatt

15. Birthplace Balto - Md

16 (a) Informant Minerva Bawlus

(b) Address 1018 Hewitt Way

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School JUN 1 1947

18 (a) Funeral director Commissioner of Health

(b) Address

JUN 20 1947 Huntington Williams M.D.
(Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29, 1947, at 2:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 28 1947 to May 29 1947 and that I last saw h[er] alive on May 29 1947

Immediate cause of death Premature Premature Separation of Placenta

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel J. Aubin M.D.

Address Sinai Hospital Date signed 6/9/47

552711

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1164 B

Registered No. 552711

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) B.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 204 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES B. WALTERS

3 (b) If veteran, name war: World War 2
3 (c) Social Security Account No. 226-26-0076

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	M

6 (b) Name of husband or wife: Frances
6 (c) If alive, give age: 25 years

7. Birth date of deceased (mo., day, yr.) Jan. 11, 1922

8. AGE: Years	Months	Days	If less than one day
25	5	6	hr. min.

9. Birthplace: Va. (Town, county, and state)
10. Usual Occupation: Welder
11. Industry or business: Builders Welders Hdw

FATHER
12. Name: Laurel North
13. Birthplace: Va.

MOTHER
14. Maiden Name: Frances Walter
15. Birthplace: 1501- Fayette St.

16 (a) Informant: " "
(b) Address: " "

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 20/47 (month) (day) (year)
(c) Cemetery or crematory: U.S National
Location: Frederick Ave

18 (a) Funeral director: Martin L Eggan's
(b) Address: 102 S 11th Ave

19 (a) JUN 20 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17, 1947 at 1:30 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Drowning

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6/14/47 at about
(b) Where did injury occur? Patapsco River
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No?
(d) Means of injury Drowned in water

23. Signature: [signature] M.D.
Medical Examiner.
Date signed

correct age is especially important. Physicians: please write the ... WITH UNFADING INK. Every item of information should be carefully supplied. The ... the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C52712

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

C52712 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1247 James St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Flora Easter

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race White | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife Late John J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1896

8. AGE: Years 51 | Months 5 | Days 13 | If less than one day, hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business

FATHER 12. Name Sidney Colburn
13. Birthplace Md.

MOTHER 14. Maiden Name Addie Gregory
15. Birthplace Va

16 (a) Informant Elmer Easter
(b) Address 1247 James St. Balto.

17 (a) London Park (Burial, cremation, or removal) (b) Date thereof 6.21.47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3901 Frederick Rd

18 (a) Funeral director Harry A. Witzke
(b) Address 1016 Edmondson Ave

19 JUN 20 1947 (Date rec'd by reg'r) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1947, at 5:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/4 1947 to 6/18 1947 and that I last saw h[illegible] alive on 6/18 1947

Immediate cause of death Uremia
Carcinoma Cervix

Duration
2 days
?

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Upton Heath M.D.
Address 70 Lg. Date signed 6/18/47

G52743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G52743 Registered No.

The cause of death should be carefully supplied. The information should be carefully supplied. The cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2738 W. Baltimore St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2738 W. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine A. Wygant

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	W.	Married

6 (b) Name of husband: John W. Wygant Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 28, 1875

8. AGE: Years	Months	Days	If less than one day
72	4	22	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Home Wife
11. Industry or business

FATHER
12. Name John J. Hostler
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Franz
15. Birthplace

16 (a) Informant John W. Wygant Sr
(b) Address 2738 W. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 22 (month) (day) 47 (year)
(c) Cemetery or crematory Lorraine Park
Location Balto. Md

18 (a) Funeral director Harry H. Mitzke
(b) Address 410 Edmondson Ave

19 (a) Filed (Date) JUN 20 1947 (b) Registrar Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/19 1947, at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/16 1946, to 6/19 1947, and that I last saw h[illegible] alive on 6/18 1947

Immediate cause of death: Arteriosclerotic Cardio Vascular Disease — Duration

Due to

Due to

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Blanche Laughlin
Address 1400 N. Payson St Date signed 6/19/47

M. D.

X

652711 (Abel) BALTIMORE CITY HEALTH DEPARTMENT 63B Registered No. 652711

CERTIFICATE OF DEATH

Please write the information should be carefully supplied. The causes of death clearly and legibly. Physicians, please write carefully. Important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2229 E Baltimore St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Reba Abel.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Max Abel
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) July 5, 1904

8. AGE: Years	Months	Days	If less than one day
42	11	14	____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housemaker
11. Industry or business Home maker

FATHER
12. Name Max Lithograph Cohen
13. Birthplace Russia

MOTHER
14. Maiden Name Miss — Gold
15. Birthplace Russia

16 (a) Informant Max Abel Husband
(b) Address 2229 E Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 20 47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Washington Blvd
Location Washington Blvd.

18 (a) Funeral director Sol Levinson Bro
(b) Address 1124-26 W North ave

19 (a) JUN 20 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1947 at 10:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 24 1947 to June 19 1947 and that I last saw h[illegible] alive on June 19 1947.

Immediate cause of death	Duration
Cardiac insufficiency	2 days
Due to Hypertensive heart	4 yrs.
Due to Hypertension	4 yrs.
Other Conditions Hypertensive cardiovascular disease. (Include pregnancy within 3 months of death)	4 yrs.

Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Saul Bachrach M. D.
Address Church Home + Hosp Date signed 6/21/47

VS 150

G52745

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH √ 186a

Registered No. G52745

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Greenspring Ave
(c) Hospital or institution: Children's Hospital School
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Dundalk.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 37 Eastehij Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME David Ross Mc Luckie

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: No

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9, 1937

8. AGE: Years 10 | Months 2 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name Robert Mc Luckie
13. Birthplace Scotland.

MOTHER
14. Maiden Name Mary Brown Owen
15. Birthplace Scotland.

16 (a) Informant Mary Brown (Mother).
(b) Address 37 Eastehij Rd. Dundalk

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 20, 1947 (month) (day) (year)
(c) Cemetery or crematory Oakleigh
Location Eastern Ave.

18 (a) Funeral director Roland L. Fyffer
(b) Address Dundalk Ave.

19 (a) JUN 20 1947 (Date rec'd by registrar) Registrar Washington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 June 1947 at 11 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9 June 1947 to 15 June 1947 and that I last saw him alive on 10 June 1947.

Immediate cause of death: Myocardial Failure — Duration ½ hr.

Due to Sub-dural Hematoma? (3 wks).
2 Emergency

Due to Trauma to occiput approx 3 wks ago (Fall)

Other Conditions Encephalitis (Type unknown) 8 mos. ago.
(Include pregnancy within 3 months of death)

Date of operation 11 June 47

Major findings of operation: Chronic traumatic (subdural) hematoma evacuated by burr hole and drain

Date of autopsy: June 1947

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 5-30-47 at ? M
(c) Where did injury occur? 37 Eastehij Rd
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? No
(e) Means of injury

23. Signature Joseph A. Eidgeway, M.D.
Address Children's Hospital School Date signed June 47

Howard J. Pearson, M. D. X

VS 2

...especially important. Physicians: please write the ... of information should be carefully supplied. The ... the causes of death clearly and legibly.

G52746

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G52746

Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1107 E. 37th Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 D
(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1107 E. 37th Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Bernice Helen Joy

3 (b) If veteran, name war	3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Thomas F. Joy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21 1874

8. AGE: Years	Months	Days	If less than one day
73	1	27	hr. min.

9. Birthplace Howard Co. Maryland (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Benjamin F. Peddicord
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret A. Dorsey
15. Birthplace Maryland

16 (a) Informant Mrs. Edith M. Linton
(b) Address 630 Colorado Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 21-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Forestlands, Baltimore Co. Md.

18 (a) Funeral director Burke Funeral Home
(b) Address 3631 Falls Road

19 JUN 20 1947 (b) Huntington Williams, M.D. Registrar
(Registered by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18- 1947, at 11:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 1947, to June 18 1947, and that I last saw her alive on June 17 1947

Immediate cause of death	Duration
Coronary Thrombosis	Hours
Due to Coronary Artery + Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Leonard Wallenstein M. D.
Address 848 W. 36th St Date signed June 21 1947

V S 150

G52747

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G52747

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 811 N. Caroline St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-5
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 811 N. Caroline St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Henry Eaton

3 (b) If veteran of what war:
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	married

6 (b) Name of husband or wife: M[illegible]
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) 3-2-1881

8. AGE: Years	Months	Days	If less than one day
66	3	16	hr. min.

9. Birthplace Littleton N. Car. (Town, county, and state)
10. Usual Occupation laborer
11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace

16 (a) Informant Otis Enton (son)
(b) Address 752 N. Gay St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof June 20/47 (month) (day) (year)
(c) Cemetery or crematory
Location Littleton N Carolina

18 (a) Funeral director Mrs. Rott A. Elliott Dft
(b) Address 1129 N. Caroline St.

19 (a) (b) Huntington Williamsport (Registrar)

JUN 20 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-18 1947 at 5:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/31 1947 to 6/18 1947 and that I last saw him alive on 6/16 1947

Immediate cause of death: Cerebral hemorrhage — Duration 5 days
Due to: hypertensive Cardiac
Due to: renal disease
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:
23. Signature: Rayner Browne
Address 500 E. Madison St Date signed 6/19/47

Rayner Browne X

PRINT PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52748

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

Registered No. G52748

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LAFAYETTE AND JOHN ST.
(c) Hospital or institution:
WOMAN'S HOSP
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 65 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 201 W. LANVALE
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country —

3 (a) FULL NAME Mattie Hack Warner

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife NONE

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 16 Dec 1881

8. AGE: Years 65 | Months 6 | Days 2 | If less than one day ____ hr. ____ min.

9. Birthplace BALTIMORE — MARYLAND
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business NONE

FATHER
12. Name OLIVER F. H. WARNER
13. Birthplace BALTIMORE, MARYLAND

MOTHER
14. Maiden Name FLORA L. MYERS
15. Birthplace BALTIMORE, MD

16 (a) Informant MATTIE HACK WARNER
(b) Address 201 W. LANVALE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June (month) (day) 194 (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md

18 (a) Funeral director Henry W. Jenkins Sons Co
(b) Address McCulloh & Oakford Sts

19 (a) JUN 20 1947 (Date received by Registrar) Cunningham Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 June 19 ____, at 12:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10 JUNE 1947, to 18 JUNE 1947, and that I last saw her alive on 18 JUNE 1947.

	Duration
Immediate cause of death CARDIO RESP. FAILURE	
Due to Pulmonary HEMORRHAGE	5 MINS.
Due to CARCINOMA OF LUNG LEFT	2 MOS.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation ____

Major findings of operations ____

of autopsy: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M.
(c) Where did injury occur? ____
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____
(Specify type of place)
(e) Means of injury ____

23. Signature Dudley B. Agnew Jr. M.D.
Address Woman's Hospital Date signed 18 June 47

VS 3

X

G52749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

G52749 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3515 OLD FREDERICK RD.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 65 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3515 OLD FREDERICK RD
(If rural give location)
(e) If foreign born, how long in U. S. A.? 65 YRS years

3 (a) FULL NAME ALBERTINE SCHERZER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex FEMALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife LOUIS SCHERZER

6 (c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) AUG. 6, 1867

8. AGE: Years 79 | Months 10 | Days 14 | If less than one day ____ hr. ____ min.

9. Birthplace GERMANY (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name HILDERBRAND
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace GERMANY

16 (a) Informant LOUIS SCHERZER
(b) Address 3515 OLD FREDERICK RD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6 23 1947 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location BALTIMORE

18 (a) Funeral director HENRY W. JENKINS & SONS
(b) Address ORCHARD & McCULLOUGH Huntington Williamsport, Md.

19 (a) JUN 20 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 1947, at 7 20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 12 1947 to June 20 1947, and that I last saw her alive on June 19 1947.

Immediate cause of death Pulmonary Edema

Duration

Due to Hypertension, Cerebral Hemorrhage

Due to Arteriosclerosis

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard G. Patterson M. D.
Address 215 W. Madison Ave. Date signed 6/20/47

VS 2

X

G52750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. G52750

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Delaware & Druid St.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 117 S. Carrollton ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Snyder Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-01-7977

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Margaret C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1916

8. AGE: Years	Months	Days	If less than one day
31	2	4 3	hr. min.

9. Birthplace Delaware (Town, county, and state)
10. Usual Occupation Machinist Helper
11. Industry or business

FATHER 12. Name John J. Snyder Sr.
13. Birthplace germany

MOTHER 14. Maiden Name Emma Mack
15. Birthplace Delaware

16 (a) Informant Mrs Margaret Snyder
(b) Address 117 S. Carrollton ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 23 1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Frederick P. Cole
(b) Address 1700 W Lombard St.

JUN 20 1947 (Date rec'd by Registrar) Lington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1947 at 7:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 9 1947 to June 19 1947, and that I last saw him alive on June 18 1947.

Immediate cause of death	Duration
Femoral dislocation	
Due to Chronic myelogenous leukemia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles R. Johnson M.D.
Address Univ. Hosp. Date signed 6/18/47

X

TYPE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FOR BINDING

G52751 — BALTIMORE CITY HEALTH DEPARTMENT — G52751 Registered No.

CERTIFICATE OF DEATH 46B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St
(c) Hospital or institution: Home for the Aged Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Lunger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29 / 67

8. AGE: Years	Months	Days	If less than one day
79	10 11	21	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Joseph Lunger
13. Birthplace

MOTHER — 14. Maiden Name Mary Gerlach
15. Birthplace

16 (a) Informant Sister & Nurses of the Poor
(b) Address 1200 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 21 / 47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Ritz Wuderfeld
(b) Address 901 E Biddle St

19 (a) JUN 20 1947 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1947, at 2:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1947 to June 19 1947, and that I last saw him alive on June 19 1947.

Immediate cause of death	Duration
Carcinoma of Stomach	1 yr.
Due to	
Due to	
Other Conditions Metastasis in Liver	2 mo.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E North Av Date signed 6/20/47

X

DO NOT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The street age is especially important. Physicians: please write the causes of death clearly and legibly.

G52752 Ball G52752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1008 N. Carey St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mon., or days) 15 yr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1008 N. Carey St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Ball

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-12-7539

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Ruth A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/5/14

8. AGE: Years 32 | Months 8 | Days 13 | If less than one day ____ hr. ____ min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Wm P. Ball

13. Birthplace Va

MOTHER 14. Maiden Name Martha E. Edwards

15. Birthplace Va

16 (a) Informant Ruth A. Ball

(b) Address 1008 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/21/47 (month) (day) (year)

(c) Cemetery or crematory Lancaster Co. Va

Location Va

18 (a) Funeral director Thos. L. Kelson

(b) Address 1303 Pennsylvania Ave

19 (a) 20 1947 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1947, at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1947 to June 18 1947, and that I last saw h— alive on June 18 1947.

Immediate cause of death (a) Uremia — Duration

Due to Chronic Interstitial Nephritis

Due to

Other Conditions Pneumonia, Pulmonary Edema.

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huntington Williams

Address 130 N. Greene St Date signed 6/19/47

VS 150

WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. DO NOT WRITE ON THIS SPACE — FOR BINDING

G52753

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G52753 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days) Over 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Rural - Woodlawn Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6704 Dogwood Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary M. Rinn

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Eugene J. Rinn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 5th 1878

8. AGE: Years 68 | Months 9 | Days 13 | If less than one day ___ hr. ___ min.

9. Birthplace New York City
(Town, county, and state)

10. Usual Occupation House work

11. Industry or business at home

FATHER
12. Name Patrick Moran
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Dolan
15. Birthplace Ireland

16 (a) Informant Mr. Eugene J. Rinn Jr
(b) Address 6704 Dogwood Rd

17 (a) Burial (b) Date thereof 6/21/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location 4300 Old Frederick Rd.

18 (a) Funeral director John J. Coyne & Son
(b) Address 901-03 N. Collins St

19 JUN 20 1947 (b) Huntington Hollins M.D.
(Date rec'd by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/18 1947, at 3:45 P.M.

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage

Due to Hypertensive C V Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ___ at ___ M.
(b) Where did injury occur?
Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature R. P. Fuchs M.D.
Medical Examiner.
Date signed 6/19/47

X

G52751 Blk D78763

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

157E

Registered No. G52751

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) dna
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Lansdowne
(If outside city or town limits, write RURAL and give town)
(d) Street No. 301 Third ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Ebberts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/5/1947

8. AGE: Years | Months: 1 | Days: 17 | If less than one day, hr. min.

9. Birthplace Baltimore, Md,
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William M. Ebberts
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Evelyn M. Gorman
15. Birthplace Baltimore Md

16 (a) Informant Mrs Wm M. Ebberts
(b) Address 308-3rd Ave, Lansdowne, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/21/47
(month) (day) (year)

(c) Cemetery or crematory Baltimore Lawn
Location End of E. North Ave

18 (a) Funeral director John J. Gorman & Son
(b) Address 901-09 Collins Street

19 (a) JUN 20 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1947, at 7:15 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Congenital Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner.
Date signed 6/20/47

Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

BINDING

C527755 B# B 7835 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 119a Registered No. C527755

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. DO NOT SOLDER FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Cypress & Cleveland
(c) Hospital or institution: East Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Since birth

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 479 E. Eutaw St. (If rural give location)
(e) Citizen of foreign country? (Eutaw St) (Yes or No)
If yes, name country

3 (a) FULL NAME Darlene M. Schwarz

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 12 - 1947

8. AGE: Years | Months 1 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Henry C. Schwarz
13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Helen R. Allen
15. Birthplace Baltimore Md.

16 (a) Informant Henry C. Schwarz
(b) Address 479 E. Eutaw St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-21-1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director Flynn & Flynn
(b) Address 1611 N. Eutaw St.

19 (a) JUN 20 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 June 1947, at 1:10 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 18 June 1947 to 19 June 1947 and that I last saw h[illegible] alive on 19 June 1947

Immediate cause of death Septicemia — Duration

Due to Cause undet.

Due to

Other Conditions Diarrhea - etiology undet. (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lester C. Hall Jr. M. D.
Address Hos + Baltimore Gen. Hosp. Date signed 6/21/47

X

G52756

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 124 B G52756

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Carlin
(c) Hospital or Institution: St Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 1400 N. Highland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL P. HANGIS

3 (b) If veteran, name war No

3 (c) Social Security Account No. 206-09-2386

4. Sex MALE

5. Color or race White

6 (a) Single, married, widowed, or divorced SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 1894

8. AGE: Years 50 | Months 6 | Days | If less than one day ____ hr. ____ min.

9. Birthplace Rhodes, Turkey
(Town, county, and state)

10. Usual Occupation Cook

11. Industry or business Res

FATHER
12. Name Frank Hangis
13. Birthplace Rhodes, Turkey

MOTHER
14. Maiden Name Mary S. Thoules
15. Birthplace Rhodes, Turkey

16 (a) Informant William Hangis
(b) Address 535 S. Halsted St. Chicago

17 (a) Burial (b) Date thereof 6/23/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Greek Orthodox
Location Evangelismos

18 (a) Funeral director Key Agency Funeral Home
(b) Address 118 W. Mt. Royal Ave

19 (a) JUN 20 1947 (b) [illegible] Baltimore, Md.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 June 1947 at 8:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 18 1947 to June 20 1947
and that I last saw h.e alive on June 9 1947.

Immediate cause of death

(a) Hypostatic pneumonia
Due to Cerebral Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

	Duration
(a)	
(b)	
(c)	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry D. Comb M.D.

Address 15 E. Eager St. Date signed 6/24/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REMOVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

652757

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

652757

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A. A. Co.
(c) City or town Linthicum (If outside city or town limits, write RURAL and give town)
(d) Street No. Hammonds Ferry Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ORVAL E. PYLE, Sr.

3 (b) If veteran, name war –

3 (c) Social Security Account No. 214-01-2080

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Virginia (Mrs.) Pyle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14, 1893

8. AGE: Years	Months	Days	If less than one day
54	3	4	hr. min.

9. Birthplace (Town, county, and state) W. Va.

10. Usual Occupation

11. Industry or business

FATHER
12. Name John H. Pyle
13. Birthplace W. Va.

MOTHER
14. Maiden Name Lucinda Poling
15. Birthplace W. Va.

16 (a) Informant Mrs. Virginia R. Pyle
(b) Address Hammonds Ferry Rd, Linthicum

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/23/47 (month) (day) (year)
(c) Cemetery or crematory MeadowRidge Cem.
Location Howard County, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 20 1947 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1947, at 4P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1947 to June 18 1947 and that I last saw him alive on June 18 1947.

Immediate cause of death	Duration
Shock	
Due to multiple myeloma, 3rd dorsal vertebra, & Bl dension to	
Due to epidural space.	
Other Conditions Pericarditis Suppurative	

(Include pregnancy within 3 months of death)

Date of operation June 18, 1947

Major findings of operation: Fluid and tumor 3rd dorsal vert.

of autopsy: multiple myeloma

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John C. Krzywicki M. D.
Address St. Agnes Hospital Date signed 6/18/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52758

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G52758

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2033 E. 31st St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2033 E. 31st St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY AUGUSTA WALTJEN

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife –
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3, 1857

8. AGE: Years	Months	Days	If less than one day
90	3	16	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Augustus W. Waltjen
13. Birthplace Unknown

MOTHER
14. Maiden Name Lucy Barton
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Emma C. Gorrell
(b) Address 2033 E. 31st St.

17 (a) Burial (b) Date thereof 6/21/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 20 1947 (Date rec'd by Registrar) Township or Village, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19, 1947, at 4:00a M

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1947 to June 18 1947, and that I last saw h[illegible] alive on June 18 1947

Immediate cause of death	Duration
Cardiac Arrhythmia	3 days
Due to Chronic Endocarditis	4 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 313 Stamford Rd Date signed June 21 M. D.

V S 150

G52759

DH # 81323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

G52759 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 918 Walnut St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10½ hr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 918 Walnut St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Linda May Braun

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	S.

6 (b) Name of husband or wife none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20, 1947

8. AGE: Years	Months	Days	If less than one day
			10½ hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Joseph William Braun
13. Birthplace Red Bank N J

MOTHER
14. Maiden Name Alice Hewett Baker
15. Birthplace Baltimore Md.

16 (a) Informant Joseph Braun
(b) Address 918 Walnut St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JUN 20 1947

18 (a) Funeral director Commissioner of Health
(b) Address
JUN 20 1947 (Local Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 1947, at 11:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1947, to June 20 1947, and that I last saw her alive on June 20 1947.

Immediate cause of death Intracranial hemorrhage — Duration 10½ hr.
Due to Prematurity 35 weeks
Due to Unknown
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature James K. Lindsay Jr. M. D.
Address 936 E. Balto St. Date signed 6/20/47

VS 3

24. X

G52760 G52760

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 300 E. 31st St.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 17 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 300 E. 31st St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Shaw Porter

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Eva Morgan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 30, 1896

8. AGE: Years	Months	Days	If less than one day
50	9	18	hr. min.

9. Birthplace Arizona (Town, county, and state)
10. Usual Occupation investment broker
11. Industry or business

FATHER
12. Name Ellis Gibson Porter
13. Birthplace

MOTHER
14. Maiden Name Ella Keen
15. Birthplace Harford County, Md.

16 (a) Informant Miss Nan Lee Porter
(b) Address 300 E. 30th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/21/47 (month) (day) (year)
(c) Cemetery or crematory Sposutia
Location Perryman, Md.

18 (a) Funeral director John A. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) 1947 (Date rec'd by Registrar) (b) Jno. Wilhelm, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 18 1947, to June 18 1947.
and that I last saw h alive on 19

Immediate cause of death	Duration
Coronary occlusion	
Due to Hypertensive cardiovascular	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen J Van Lill III M. D.
Address 2843 St. Paul St. Date signed 6-20-47

X

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52761
MH

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G52761
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3½ years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Davisonville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sterling Collins or Sterlinga Collins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 12, 1943

8. AGE: Years	Months	Days	If less than one day
3	7	6	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Thomas Collins
13. Birthplace North Carolina

MOTHER
14. Maiden Name Blanche Bell Faulk
15. Birthplace North Carolina

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Interment (Burial, cremation, or removal) (b) Date thereof 6/20/47 (month) (day) (year)
(c) Cemetery or crematory Dorsey Sta.
Location N.C. Road near Dorsey

18 (a) Funeral director A. Halsted
(b) Address 918 Druid Hill Ave

19 (a) JUN 20 1947 (b) Registrar
(Date received by registrar)
Kensington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 19 47, at 8:20 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 14 19 47 to June 18 19 47 and that I last saw him alive on June 18 19 47.

Immediate cause of death	Duration
Retinoblastoma Rt. eye	6 mon.
Due to	
Due to	
Other Conditions Meningitis	2 days?

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy Medulloblastoma & Meningitis

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Julian P. Griffin
Address Balt. City Hosp. Date signed 8 June 1947

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52762 — GM. 94903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G52762 — Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 10 28
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. ~~No Home~~ 1908 Penrose Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hardy John (John T. Hardy)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Katie Hardy (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1 - ~~1881~~ 1871

8. AGE: Years ~~65~~ 75 | Months 6 | Days 18 | If less than one day ... hr. ... min.

9. Birthplace MD. Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER — 12. Name ~~Samuel (D)~~ Samuel J. Hardy

13. Birthplace MD Baltimore

MOTHER — 14. Maiden Name Rachel ~~Talbert~~ Galloway (D)

15. Birthplace MD. Baltimore

16 (a) Informant Records Balto. City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 21,1947 (month) (day) (year)

(c) Cemetery or crematory Western Cemetery

Location Baltimore, Md.

18 (a) Funeral Director Wilbur Lamborn

(b) Address 1003 W. Baltimore St.

19 (a) Date received by registrar JUN 20 1947 (b) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June -19- 1947, at 1.30A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 21 - 1945, to June 19 - 1947, and that I last saw h im alive on June 19 - 1947

Immediate cause of death: Respiratory Failure — Duration:

Due to: Congestive Heart Failure —

Due to: Hypertensive Heart Disease —

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: None done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ... at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature W. R. Scarborough M. D.

Address Balto City Hosp Date signed 6-19-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52763

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 131 B 763

Registered G52763

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkins Ave.
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 65 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Taneytown
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Rothgaber

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife William Laurence Rothgaber
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1905

8. AGE: Years	Months	Days	If less than one day
42	0	21	hr. min.

9. Birthplace Cork - Ireland (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business own home

FATHER
12. Name Michael O'Sullivan
13. Birthplace Ireland

MOTHER
14. Maiden Name Ann Kennedy
15. Birthplace Ireland

16 (a) Informant Laurence Rothgaber
(b) Address Taneytown Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 24, 1947 (month) (day) (year)
(c) Cemetery or crematory St. Joseph's Cemetery
Location Taneytown, Md.

18 (a) Funeral director C. O. Fuss & Son
(b) Address Taneytown, Md.

JUN 20 1947 (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/20 1947, at 12:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 17 1947, to June 20 1947, and that I last saw her alive on June 20 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to Chronic glomerular nephritis	2 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Herbert J. Linka
Address Agnes Hosp. Date signed 6/20/47

JUN 21 1947

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52764 A - 111335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

137a

Registered No. G52764

764

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1203 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Ambrose

3 (b) If veteran, name war (W)

3 (c) Social Security Account No. 212-18-0449

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Julia Ambrose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 26, 1872

8. AGE: Years 75 | Months 2 | Days 23 | If less than one day ____ hr. ____ min.

9. Birthplace Md. (Balto. Co.)
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business Bricklayer

FATHER
12. Name George Ambrose
13. Birthplace Md.

MOTHER
14. Maiden Name Ella Ula
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 6/23/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glenburnie Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 E. Paul St

19 (a) JUN 21 1947 Huntington Williams M.D.

JUN 21 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1947, at 10:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1947 to June 19 1947, and that I last saw him alive on June 19 1947

	Duration
Immediate cause of death: Uremia	Days
Due to: Ureteral Tract Obstruction and Infection	15 yrs.
Due to: BPH - Operation 1936	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edmund B. Coulam M. D.
Address BCH Date signed June 20 47

JUN 21 1947

G52765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G52765 765

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Daa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1806 E. Lafayette Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Myrtle A. Hancock

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband Lawrence J. Hancock

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8th 1908

8. AGE: Years	Months	Days	If less than one day
39	2	11	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER — 12. Name Daniel T. Poston
13. Birthplace Balto. Md.

MOTHER — 14. Maiden Name Marie McLaughlin
15. Birthplace Balto. Md.

16 (a) Informant Elmer J. Poston
(b) Address Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/23/47 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cemetery
Location Edmondson Ave

18 (a) Funeral director William Cook Inc
(b) Address St. Paul St

19 (a) Filed JUN 21 1947 (b) Registered by reg. JUN 21 1947 Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1947 at 10 45 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Hus death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mullen M.D. Medical Examiner.
Date signed 6-19-47

X

G52766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61 ✓ Registered No. 726 G52766

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 Park Avenue
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 Park Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Florence Matthews Fluharty

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: NONE

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: T. Edgar
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: About 86 | Months | Days | If less than one day: hr. min.

9. Birthplace: Ottumwa, Iowa (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Hugh W. Matthews
13. Birthplace: England

MOTHER
14. Maiden Name: Unknown
15. Birthplace: England

16 (a) Informant: Edgar M. Fluharty
(b) Address: Kingsville, Maryland

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 6/21/47 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge
Location: Pikesville, Maryland

18 (a) Funeral director: Wm. Cook, Inc.
(b) Address: 1217 St. Paul Street

19 (a) JUN 20 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

JUN 21 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18, 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1940 to June 18 1947. and that I last saw her alive on June 18 1947.

Immediate cause of death: Cerebral Hemorrhage — Duration: 1 hr
Due to: Arterio-Sclerosis — Myocarditis — Gradual ✓
Due to: Hypertension — Diabetes Mellitus — ✓ ✓
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature: W H Moody M.D.
Address: Date signed 6/20/47

X

G52767

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G52767

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 S. Savage St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 600 S Savage St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Agnes Basara

3 (b) If veteran, name war | 3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife George Basara
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER	12. Name George Kacper
	13. Birthplace Poland
MOTHER	14. Maiden Name Nowakowski
	15. Birthplace Poland

16 (a) Informant George Basara
(b) Address 600 S. Savage St

17 (a) (Burial, cremation, or removal) (b) Date thereof June 23/47 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore

18 (a) Funeral director Fred W. Ozmanski
(b) Address 1930 Eastern Ave

19 JUN 21 1947 (b) Huntington Williams, M.D.
(Clerk, or city, registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1947, at 6:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 to June 19 1947; and that I last saw h[illegible] alive on June 19 1947.

	Duration
Immediate cause of death Hypertensive Cardiovascular Renal Disease	?
Due to	
Due to	
Other Conditions No Trauma	Denies

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert J. Likavsky, M.D.
Address 1939 N. Fulton Ave Date signed June 20th 1947

VS 150

G52768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. G52768

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 220 E. Montgomery st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jacob Myers

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: MARIE WAGNER

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) JAN 5, 1884

8. AGE: Years 63 | Months 5 | Days 14 | If less than one day ____ hr. ____ min.

9. Birthplace AUSTRIA (Town, county, and state)

10. Usual Occupation

11. Industry or business PAPER MILL

FATHER
12. Name THOMAS LEIFERT
13. Birthplace AUSTRIA

MOTHER
14. Maiden Name ELIZABETH ——
15. Birthplace AUSTRIA.

16 (a) Informant MR. JOHN W KING
(b) Address 220 E. MONTGOMERY ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6/23/47 (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS
Location RITCHIE HIGHWAY

18 (a) Funeral director JOHN F. DENNY, INC.
(b) Address 715 LIGHT ST.

19 (a) JUN 21 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1947, at 11 15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Chest.

Due to

Other Conditions Fractured rt. humerus, rt radius + rt. Clavicle.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 24/1

(a) Date of injury 6/19/47 at 11 P.M.
(b) Where did injury occur? Fort Ave. + Woodall st
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto

23. Signature [signature] M.D. Medical Examiner.

Date signed 6-20-47

MARGIN RESERVED FOR BINDING

Please write plainly, with unfading ink. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164c

Registered No. G52769

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp. 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2601 Garrett avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Herman Wilson Pearce

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 217-03-6944

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Margaret A. Pearce

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1902

8. AGE: Years 44 34 | Months 9 | Days 17 | If less than one day hr. min.

9. Birthplace Fork, Md. (Town, county, and state)

10. Usual Occupation Paper Hanger

11. Industry or business

FATHER
12. Name Parker Pearce
13. Birthplace Fork, Md.

MOTHER
14. Maiden Name Katherine Kramer
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Margaret A. Pearce
(b) Address 2601 Garrett Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/23/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JUN 21 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1947, at 3:25 P.M.

21. I certify that I took charge of the remains described above, held an Inqu. & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Hom death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Gunshot wound of head involving brain

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-19-47 at 2:00 P M (?)
(b) Where did injury occur? Mt. Pleasant Park (on Belair Rd.)
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? no
(d) Means of injury 2 gunshots 16 gage shotgun

23. Signature Earl K. Long M.D. Medical Examiner.
Date signed 6-20-47

52770

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 127B

Registered No. 52770

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5
(c) Hospital or institution: Maryland Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2311 Calvert on Ht and #14
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY C. BUCKINGHAM

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-01-0295

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	White	MARRIED

6 (b) Name of husband or wife MARY BUCKINGHAM
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7. 18. 1885

8. AGE: Years	Months	Days	If less than one day
61 62	11	2	hr. min.

9. Birthplace Washington D. C.
(Town, county, and state)
10. Usual Occupation ELECTRICIAN
11. Industry or business Stanley Theater

FATHER
12. Name HARRY C. BUCKINGHAM
13. Birthplace Washington D.C.

MOTHER
14. Maiden Name MARY HILL
15. Birthplace Baltimore, Md.

16 (a) Informant Mary Buckingham
(b) Address 2311 Calverton Heights #14

17 (a) Cremation (b) Date thereof 6/24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 JUNE 21 1947 (b) Huntington Williams, M.D.
(Signature of city registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 - 20 - 1947 at 2:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6:19 1947 to 6:20 1947 and that I last saw him alive on 6:20 1947

Immediate cause of death Peritonitis — Duration

Due to Ruptured Gall Bladder

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: Gen. Peritonitis Ruptured Gall Bladder

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard E. Martin M. D.
Address Maryland Gen. Hospital Date signed 6-20-47

G52771

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G52771

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Severn Park
(If outside city or town limits, write RURAL and give town)
(d) Street No. Cypress Creek Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Margaret Saltzmann

3 (b) If veteran, name war	3 (c) Social Security Account No.
✓	✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	M

6 (b) Name of husband or wife Adam Saltzmann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 2, 1886

8. AGE: Years	Months	Days	If less than one day
61	5	18	hr. min.

9. Birthplace Maryland Balto,
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business at home

FATHER
12. Name Philip Zollers
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Dora
15. Birthplace Baltimore Md.

16 (a) Informant Adam Saltzmann
(b) Address Severn Park Md

17 (a) Burial (b) Date thereof 6/23/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn Md.

18 (a) Funeral director John J. Coyne & Son
(b) Address 901-03 Hollins St

19 JUN 21 1947 (Signature of local registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/20 1947, at 9:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/17 1947, to 6/20 1947, and that I last saw h[illegible] alive on 6/20 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Pneumonia, lobular	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature August Kiel M. D.
Address Mercy Hosp. Date signed 6/20/47

VS 150

G52772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13/a

Registered No. G52772

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2119 Madison Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2119 Madison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emily Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	Widow

6 (b) Name of husband or wife Unknown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1862

8. AGE: Years	Months	Days	If less than one day
85			hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Thomas Smith
(b) Address 2119 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 14, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Kate R Williams
(b) Address 322 N. Schroeder St

19 (a) (b) Huntington Williams, M.D. Registrar

Filed JUN 21 1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/11 1947, at 4:45 P.M

21. I certify that death occurred on the date above stated, that I attended deceased from 4/11 1947 to 6/11 1947, and that I last saw h. alive on 6/11 1947.

Immediate cause of death	Duration
(a) Edema of glottis & laryngeal tissues	6 mos.
Due to (b) Carcinoma of cervix uteri	1 yr.
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 600 N. Hampton Apt. 7

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

GASKINS

G52773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G52773 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 824 N. Carrollton av.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 824 N. Carrollton ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Joseph Gaskins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M. | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Hattie Gaskins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 75 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Custodian

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Hattie Gaskins
(b) Address 824 N. Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/23/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Meg. H. Kelson
(b) Address 1303 Pleasant Ave

19 (a) JUN 21 1947 (Date of registration) Huntington for Nathaniel Mrs Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 1947, at 3 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/17/1947 to 6/20/1947 and that I last saw him alive on 6/17/1947.

Immediate cause of death Chronic Myocarditis — Duration 2 yrs.

Due to

Due to

Other Conditions Cardiac Cachexia

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Marcell Lawrence M. D.
Address 1033 W. Lanvale St. Date signed 6/21/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52774

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G52774

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20a
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3213 Ft. Paul St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Harry Perry

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Divorced
6 (b) Name of husband or wife: Minnie Emma Perry
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 21 1898 (1908)

8. AGE: Years (49) 48 | Months 9 | Days 11 | If less than one day ..... hr. ..... min.

9. Birthplace Lackawaxen, Penna.
(Town, county, and state)

10. Usual Occupation Unknown

11. Industry or business

FATHER 12. Name Emory Louis Perry
13. Birthplace —

MOTHER 14. Maiden Name Minerva H.
15. Birthplace —

16 (a) Informant Carson B Perry
(b) Address 1376 Clinton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 23-47 (month) (day) (year)
(c) Cemetery or crematory Balto National
Location Balto Md.

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights

19 JUN 21 1947 (Date filed by registrar) Huntington Williams M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 1947, at 9:35 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Due to acute congestive heart failure

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Carson B Perry M.D.
Medical Examiner.
Date signed 6-2-47

G52775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G52775 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 845 Park Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mathew Page Andrews

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Removal (b) Date thereof 6-21-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Charlestown W. Va.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address 4 North & Penna Ave

JUN 21 1947 (b) Huntington Williams M.D.
(Date filed by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 1947 at 8:00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 6-21-47

G52776 BALTIMORE CITY HEALTH DEPARTMENT Registered No. G52776

No. BR-67462 CERTIFICATE OF DEATH 13

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 567 Dolphin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Beverly Evans

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 11, 1947

8. AGE: Years	Months	Days	If less than one day
	5	9	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Joseph Evans
13. Birthplace Virginia

MOTHER
14. Maiden Name Helen Brown
15. Birthplace Maryland

16 (a) Informant Isabelle Brown
(b) Address 567 Dolphin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 21, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Wm. George A. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) JUN 21 1947 (b) Huntington Williams, M.D. Registrar

V S 190

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 1947, at 4:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1947 to June 20 1947 and that I last saw her alive on June 20 1947

Immediate cause of death	Duration
Tuberculous Meningitis	2 wks.
Due to	
Due to Tuberculosis Miliary	1 month
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Julian P. Griffin M. D.
Address Balt. City Hosps. Date signed June 23 '47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52777 M

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47c ✓ Registered No. G52777

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 3 10
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 432 Grundy St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME John Reuter

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17, 1882

8. AGE: Years 65 | Months 2 | Days 2 | If less than one day ____hr. ____min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Bricklayer
11. Industry or business

FATHER
12. Name Casper Reuter
13. Birthplace Maryland

MOTHER
14. Maiden Name Dorothy Miller
15. Birthplace Germany

16 (a) Informant Records at Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-23-1947 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem
Location German Hill Rd.

18 (a) Funeral director Lilly & Zeiler Inc
(b) Address 403 S. Wolfe St.

19 (a) JUN 21 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 19 47, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 9 19 43 to June 19 19 47 and that I last saw h im alive on June 19 19 47.

Immediate cause of death: Carcinoma Stomach
Due to: Carcinoma ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)

	Duration
Due to Carcinoma ?	over

Date of operation
Major findings of operation:
of autopsy: None additional

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

PHYSICIAN
Underline the cause to which death should be charged statistically.

23. Signature J. C. Robinson Jr. M. D.
Address Balt. City Hosp. Date signed 6/20/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G52778

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 339 Macon Street, South
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ~7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 339 South Macon Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Antone Boehm~~ Anton J. Boehm Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mary Miller

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2-6-1896

8. AGE: Years 51 Months 4 Days 15 If less than one day — hr. — min.

9. Birthplace: Baltimore
(Town, county, and state)

10. Usual Occupation: Electrician

11. Industry or business: Beth. Steel Co.

FATHER
12. Name: John Boehm
13. Birthplace: Germany

MOTHER
14. Maiden Name: Barbara ?
15. Birthplace: ?

16 (a) Informant: Mary Boehm - wife
(b) Address: 339 S. Macon St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-23-47 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn
Location: Eastern Ave.

18 (a) Funeral director: Lilly & Zeigler
(b) Address: 403 S. Wolfe St.

19 (a) JUN 21 1947 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19, 1947, at 4:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary occlusion

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature: [illegible] M.D. (Medical Examiner)
Date signed 6-19-47

VS 191

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G52779
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 551 Orchard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 551 Orchard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucille Stinnay

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 17, 1925

8. AGE: Years	Months	Days	If less than one day
22	4	1	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles Queen
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Moore
15. Birthplace Md.

16 (a) Informant Angie Queen
(b) Address 551 Orchard St.

17 (a) Burial (b) Date thereof 6-23-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

JUN 24 1947 (Date received by registrar) (By) Washington Witherspoon

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1947, at 10 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil Kruger M.D.
Medical Examiner.
Date signed 6-19-47

VS 191

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G52780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

G52780 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 N. Calvert St.
(c) Hospital or institution: home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto. City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? — No — (Yes or No) If yes, name country

3 (a) FULL NAME Frances Rebecca Russell

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband ~~or wife~~ Lewis H. Russell
6 (c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) Oct. 10 1863

8. AGE: Years	Months	Days	If less than one day
83	8	10	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER 12. Name Silas Phelps.
13. Birthplace Maryland.

MOTHER 14. Maiden Name Eleanor M. Loughlin
15. Birthplace Maryland.

16 (a) Informant Edw L. Russell (Son)
(b) Address 2128 N Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-23-1947 (month) (day) (year)
(c) Cemetery or crematory Westerin
Location Balto. - Md.

18 (a) Funeral director Sherwood Morgan & Co.
(b) Address 108 W Mt Royal Ave.

19 (a) JUN 22 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 1947, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1946, to June 20 1947; and that I last saw h alive on June 20 1947.

Immediate cause of death	Duration
Cardiac Decompensation	1 mo
Due to	
Generalized Arteriosclerosis	5 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hubert F. Rieman M. D.
Address 6 Biddle St Date signed 6/24/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

106 c

G52781

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4500 Garrison
(c) Hospital or institution: The Shawen (rest home)
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4500 Garrison
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel McCutcheon Reid

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Anna E. Reid

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept-5-1855

8. AGE: Years 91 | Months 9 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name William Reid
13. Birthplace ? - U.S.A.

MOTHER
14. Maiden Name Agnes McCutcheon
15. Birthplace ? - U.S.A.

16 (a) Informant Mrs Paul Strassmann
(b) Address 4100 Fernhill Ave (10)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6- -47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Edward Lomax Co
(b) Address 1084 W North Ave

JUN 22 1947 (Date rec'd by registrar) (Transcription for William H. Reid)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/20 19 , at 9:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased about 2 19 48 19 47
and that I last saw him alive on 6/20 19 47

Immediate cause of death: arterio sclerosis, hypostatic pneumonia, senility — Duration: several yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hyman Greenfield M.D.

Address 3902 Greenlea Date signed 6/21/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

53

G52782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G52782
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 322 E. 33rd St.
(c) Hospital or institution: home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 322 E. 33rd St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. ETHEL-MAY- Noel

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Jacob - S - Noel

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 20 1879

8. AGE: Years 68 | Months 2 | Days 1 | If less than one day: hr. min.

9. Birthplace probably Virginia
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Thos. B. Hicks
13. Birthplace Virginia

MOTHER
14. Maiden Name Alice Jorden
15. Birthplace Virginia

16 (a) Informant Mrs. Jos. Johnson (niece)
(b) Address Baltimore.

17 (a) Burial (b) Date thereof 6-23-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ?
Location Richmond - Virginia

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. Mowen Asst.) 100 N. North Avenue

19 (a) (b)
(Date filed by registrar) Registrar

JUN 23 1947

VS 450

Mortician for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1947, at 4:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1935 to June 21 1947, and that I last saw her alive on June 20 1947.

Immediate cause of death
Myocarditis
Arterio-Sclerosis
Due to Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration
Gradual

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Moody M.D.
Address 1403 Parkside Date signed 6/24/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G52783 Registered No. 186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere Ave
(c) Hospital or institution: Lyric Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 2 3 4 5

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. Dunspury Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) V
If yes, name country

3 (a) FULL NAME CHAIM GEDALJA KONIG V

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Freda
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1857

8. AGE: Years 90 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Benj Leitsman
(b) Address 700 N. Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-22-47 (month) (day) (year)
(c) Cemetery or crematory Greenlawn
Location Plot 864

18 (a) Funeral director Louis Levin Inc
(b) Address 2100 E. Eager St
(c) Date received by registrar JUN 23 1947 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-22 1947 at 8 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-23 1944 to 6-22 1947 and that I last saw h[illegible] alive on 6-22 1947

Immediate cause of death Bilateral bronchopneumonia
Due to Hip fracture
Due to
Other Conditions Intestinal obstruction ?
(Include pregnancy within 3 months of death)

Duration:

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 6/16/47 M
(c) Where did injury occur? Lansdale Pa (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public (Specify type of place) While at work? No
(e) Means of injury Fell off bed

23. Signature Howard J. Mensgin, M.D.
Address Lansdale Home Date signed 6-22-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52784

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G52784
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 13
(c) Hospital or institution: West Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2206 Eyanbrook Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Norman Gordon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Florence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1912

8. AGE: Years 35 | Months | Days | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Display man

11. Industry or business

FATHER
12. Name John Gordon
13. Birthplace Buffalo NY

MOTHER
14. Maiden Name Shirley Cornsteen
15. Birthplace Russia

16 (a) Informant Florence Gordon
(b) Address 2206 Eyubrook ave

17 (a) Burial (b) Date thereof 6-22-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory B'nai Israel
Location Southern ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1409 E Balto St

19 (a) (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

JUN 27 1947

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 1947 at 10:45 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary artery disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Rogers M.D.
Medical Examiner
Date signed 6-21-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G52785

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G52785 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4115 PK. Hgts Ave
(c) Hospital or institution Mt. Sinai Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 142 N. Exeter St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Schoolenick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Simon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Home Work

11. Industry or business

FATHER
12. Name Phelps
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Family Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-22-47 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Germans Hill Rd

18 (a) Funeral director Jack Levy Inc
(b) Address 1439 E. Baltimore St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-20-47 19 , at 8 45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-15 1947 to 6/20 1947 and that I last saw he alive on 6/20 1947

Immediate cause of death Acute Cerebral Hemorrhage — Duration

Due to Ch. Hypertension

Due to Ch. Myocarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. L. Hornstein M. D.

Address 733 Lexington St Date signed 6/21/47

22 VS 1947

Washington Williams, M Registrar

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G52786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G52786
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mercy Hosp Calvert St
(c) Hospital or institution: Mercy Hospital 76
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3418 E. Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie E. Stephens

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/8/1872

8. AGE: Years	Months	Days	If less than one day
75	5	3	1 hr. — min.

9. Birthplace Penna
(Town, county, and state)
10. Usual Occupation Cl'k Telephone Co
11. Industry or business

FATHER
12. Name William C. Enfield
13. Birthplace Penna.

MOTHER
14. Maiden Name Banks
15. Birthplace Penna

16 (a) Informant Alberta H. Butler
(b) Address 3418 E. Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 24, 1947 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Taylor Avenue

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. Wolfe Street

22 1947 Huntington Williams, Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1947 at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1947 to June 21 1947 and that I last saw her alive on June 21 1947.

	Duration
Immediate cause of death Obstruction	
Due to Bowel - with	
Perforation 3 yrs duration	
Due to Probable Carcinoma	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Lawrence J. Frey M. D.
Address Mercy Hosp Date signed 6-21-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52787

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

Registered No. G52787

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 314 S. CLINTON ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 314 S. CLINTON ST. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME FRANK E. PAZOUREK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife FRANCES GUMMER
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 10 - 13 - 1887

8. AGE: Years	Months	Days	If less than one day
59	8	7	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation CLERK
11. Industry or business —

FATHER
12. Name PETER PAZOUREK
13. Birthplace CHECKO.

MOTHER
14. Maiden Name ANNA ?
15. Birthplace ?

16 (a) Informant FRANCES PAZOUREK
(b) Address 314 S. CLINTON ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6 - 24 - 1947 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER CEM.
Location BELAIR ROAD

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. WOLFE ST.

19 (a) (Date received by registrar) (b) Hunter for Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 20, 1947, at 1:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 18 1942 to Jun 20 1947, and that I last saw h. alive on Jun 19 1947

Immediate cause of death	Duration
Carcinoma of Lungs — Metastatic	
Due to Degenerative Renal	1940
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature C. J. Goodman M. D.
Address 3426 Bank St Date signed 6/24/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C52788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 131a

Register C52788

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Lombard
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Arbutus
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christine Pavlick (Pavlik)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. (Single)

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1929

8. AGE: Years 17 | Months 9 | Days 24 | If less than one day ..... hr. ..... min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Order clerk

11. Industry or business Montgomery Ward

FATHER
12. Name Walter J Pavlik
13. Birthplace Hungary

MOTHER
14. Maiden Name Tillie
15. Birthplace Md

16 (a) Informant Walter J Pavlik
(b) Address 1208 Taylor ave (Halethorpe)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 27 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3201 Frederick Rd

18 (a) Funeral director Harry H Wilhide
(b) Address 4104 Edmondson Ave

19 (a) JUN 23 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 20 1947, at 1 39 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-19 1947 to 6-20 1947, and that I last saw her alive on 6-20 1947.

Immediate cause of death	Duration
Uremia	
Chronic Glomerulonephritis	
Hypertension & Cardiac	
Due to Endangered	
Pneumonia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H H Kasemeyer M. D.
Address University Hospital Date signed 6/28/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1272

G52789 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2550 Wilkens Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susan Shipley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband ~~or wife~~ Benjamin F.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1884

8. AGE: Years	Months	Days	If less than one day
62	8	5	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm Chenoweth
13. Birthplace Maryland

MOTHER
14. Maiden Name Susan DeVees
15. Birthplace Maryland

16 (a) Informant Benjamin F. Shipley
(b) Address 2550 Wilkens Ave

17 (a) Burial (b) Date thereof June 24, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave

18 (a) Funeral director Henry H Wright
(b) Address 4101 Edmondson Ave

JUN 23 1947 (b) Huntington Williams M.D.
(Date filed by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-20 1947, at 9:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-8 1947, to 6-20 1947, and that I last saw her alive on 6-20 1947.

Immediate cause of death	Duration
Generalized biliary tuberculosis, pulmonary, non-active	
Due to cholangiolithiasis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation ~~cholecystectomy~~
Major findings of operation: Cholangiolithiasis
of autopsy: generalized biliary tuberculosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J B Hurley M. D.
Address 1501 N. Broadway Date signed 6-21-47

G52790

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G52790

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2600 Ulman Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
2600 Ulman Ave
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Gerber

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Louis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation
11. Industry or business: House Work

FATHER
12. Name: Joseph Mendelson
13. Birthplace: Russia

MOTHER
14. Maiden Name: Elka ?
15. Birthplace: Russia

16 (a) Informant: Mr Louis Gerber
(b) Address: 2600 Ulman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 23, 1947 (month) (day) (year)
(c) Cemetery or crematory: Rosedale
Location

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

19 (a) JUN 23 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION 2.45

20. DATE OF DEATH June 22 1947, at A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1947, to June 22 1947, and that I last saw h.. alive on June 22 1947.

Immediate cause of death	Duration
Coronary Thrombosis	4 wks
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hector A. Colmers M.D. M. D.
Address 3700 Park Heights Ave Date signed June 24 1947

VS 150

X

G52791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1256

G52791

Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1535 Argyle av

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14

(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)

(d) Street No. 1535 Argyle av (If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mary D. Fisher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex fem

5. Color or race col

6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife George Fisher

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Frederick, Md. (Town, county, and state)

10. Usual Occupation domestic

11. Industry or business

FATHER 12. Name Jno Fisher

13. Birthplace Frederick, Md

MOTHER 14. Maiden Name Mary D. Fishpe

15. Birthplace Fayetteville, Md.

16 (a) Informant Medora Brown

(b) Address 1541 Argyle av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-23-47 (month) (day) (year)

(c) Cemetery or crematory Mt. Lubavan Cem

Location Baltimore, Md.

18 (a) Funeral director Wm. D. Frances A. Hemsley

(b) Address 578 W. Biddle St.

19 JUN 23 1947 (Date rec'd by registrar) (b) Courtesy of Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19, 1947, at 6.15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 27, 1946 to June 19, 1946 and that I last saw h[illegible] alive on 16 [illegible] 1946.

Immediate cause of death Hiatal hernia with strangulation and obstruction with gastric ulcer

Due to [illegible]

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature E. B. Evans, Jr. M.D.

Address 420 N. Greene St. Date signed 6/19/47

VS 2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

552792

BALTIMORE CITY HEALTH DEPARTMENT

Ruhmann CERTIFICATE OF DEATH 51B

Register 552792

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 32nd & Calvert Streets (1e)
(c) Hospital or institution: Union Memorial Hospital 9w
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo, 24
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (1-8)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3928 Fribby Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM JOSEPH RUHMANN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7, 1892

8. AGE: Years	Months	Days	If less than one day
54	7	19	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and State)

10. Usual Occupation Office Work

11. Industry or business

FATHER
12. Name Joseph Ruhmann
13. Birthplace Maryland

MOTHER
14. Maiden Name Marie ?
15. Birthplace Maryland

16 (a) Informant Mrs. Banfield
(b) Address 3928 Fribby Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 24 47 (month) (day) (year)
(c) Cemetery or crematory Loudon Presbyterian
Location Baltimore Md.

18 (a) Funeral director Thos. G. Wilson
(b) Address 424 Fremont Ave

19 (a) JUN 23 1947 Huntington Williams, M

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 1947, at 1.20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947 to June 20 1947 and that I last saw h[illegible] alive on June 19 1947

Immediate cause of death Uraemia — Duration 3 days

Due to Carcinoma of Prostate

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4-3-47

Major findings of operation: Ca of Prostate

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James Mc C. Finney M. D.

Address Union Memorial Hosp. Date signed 6-20-47

652793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 467

Registered № 652793

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Camp Creek (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel Meadows

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Theresa

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-27-76

8. AGE: Years 71 | Months 2 | Days 26 | If less than one day hr. min.

9. Birthplace W. Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Samuel Meadows
13. Birthplace W. Va.

MOTHER 14. Maiden Name Betty
15. Birthplace W. Va.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/23/47 (month) (day) (year)
(c) Cemetery or crematory Braxmer
Location Flat Top, W. Va.

18 (a) Funeral director John O. Mitchell Undertaker
(b) Address 1900 Eutaw Place

19 JUN 23 1947 (Date rec'd by registrar) (b) Huntington, West Virginia

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1947, at 8 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1947 to June 22 1947 and that I last saw him alive on June 22 1947.

Immediate cause of death: (Interval between onset and death) Duration
Carcinoma of Rectum

Due to

Due to

Other Conditions Peritonitis

(Include pregnancy within 3 months of death)

Date of operation 6/17/47

Major findings of operation: CA Rectum

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John G. Taylor Spence M.D.
Address Johns Hopkins Hospital Date signed 6-22-47

G52794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G52794

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4806 Holder Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4806 Holder Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew F. Thelen

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Ellen Thelen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 3-1867

8. AGE: Years 80 | Months 5 | Days 18 | If less than one day hr. min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Peter Thelen
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Ruthnia
15. Birthplace Germany

16 (a) Informant Mrs Edward Myers
(b) Address 4806 Holder Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 24-47 (month) (day) (year)
(c) Cemetery or crematory Pikesville
Location Balto

18 (a) Funeral director J. J. Herr & Son
(b) Address 3091 Pinkney ave

19 JUN 23 1947 (Date received by registrar) (By) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1947, at 7.55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to June 21 1947 and that I last saw him alive on June 18 1947.

Immediate cause of death Cardiac failure
Due to Pulmonary edema
Due to Arteriosclerotic cardiac vascular disease
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Harry Mayer
Address 418 Hayford Rd. Date signed 6/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52795

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. G52795

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4624 Reisterstown Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lena Shuster

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Benjamin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Samuel Zack
13. Birthplace Russia

MOTHER
14. Maiden Name Rachael
15. Birthplace Russia

16 (a) Informant Ben. Shuster
(b) Address 4624 Reisterstown Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-23-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phila Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1429 E. Balto St

19 JUN 23 1947 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/22 1947, at 8P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/30 1947, to 6/22 1947, and that I last saw her alive on 6/22 1947

Immediate cause of death	Duration
(a) Uremia	
Due to (b) Carcinomatosis	
Due to (c) Carcinoma of Ovary	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 6/16/47
Major findings of operation Carcinomatosis
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Rubin, M.D.
Address Sinai Hospital Date signed 6/23/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 556

G52796 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 Park Heights Ave
(c) Hospital or institution Mt Sinai Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4613 Park Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jack Flinkman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years 42 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Phelps
13. Birthplace Russia

MOTHER
14. Maiden Name Fannie
15. Birthplace Russia

16 (a) Informant Mrs Edna Hadley
(b) Address 1908 Walbrook Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-23-47 (month) (day) (year)
(c) Cemetery or crematory Location Hebrew Mt Carmel

18 (a) Funeral director Jack Lewis Inc
(b) Address 1299 E Balto St

19 (a) (b) Registrar

JUN 23 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-22- 1947 at 8 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/22 1947, to 6/22 1947, and that I last saw h alive on 6/20 1947.

Immediate cause of death	Duration
General metastasis carcinoma	?
Due to Carcinoma primary lesion undetermined	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation April 1947
Major findings of operation: Removed glands in neck - carcinoma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank Lemmon M. D.
Address 4004 Liberty Heights Ave Date signed 6/23/47

X

G52797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 937

Registered No. G52797

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3114 Clearview Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Frederick
(c) City or town Frederick (If outside city or town limits, write RURAL and give town)
(d) Street No. East 8th Street Extended (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clinton Allen Kreimer

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widower

6 (b) Name of husband or wife Ethel B. Kreimer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1871

8. AGE: Years	Months	Days	If less than one day
76	0	12	hr. min.

9. Birthplace Frederick Co., Md. (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Jerome Kreimer
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth A. Eaton
15. Birthplace Holland

16 (a) Informant Mr. Clinton A. Kreimer, Jr
(b) Address Union Bridge, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-25-47 (month) (day) (year)
(c) Cemetery or crematory Liberty
Location Libertytown, Md.

18 (a) Funeral director M. R. Etchison & Son
(b) Address Frederick, Md.

19 (a) JUN 23 1947 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/22/47 19 , at 9:55 P M

21. I certify that I took charge of the remains described above, held an Inspection on thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to Time death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Dawson M.D.
Medical Examiner.
Date signed 6/22/47

X

G52798

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G52798

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Eaton & Wilkens Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hours
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 23 Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2410 Frederick Ave
(If rural give location)
(e) Citizen of foreign country? Ma. (Yes or No)
If yes, name country

3 (a) FULL NAME Mollie Clopein

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Henry Clopein
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1869

8. AGE: Years 78 | Months 5 | Days 20 | If less than one day ____ hr. ____ min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Meyers
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine ?
15. Birthplace Germany

16 (a) Informant Allen Henry Clopein
(b) Address 2410 Frederick Avenue

17 (a) Burial (b) Date thereof 6-25-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director George L. Shuat
(b) Address 2616 Frederick Avenue

19 JUN 23 1947 (Date rec'd by registrar) (b) Huntington Willis, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21 1947, at 8:45 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 21 1947 to June 21 1947, and that I last saw h-ex alive on June 21 1947

Immediate cause of death: Cerebro-Vascular accident — Duration
Transition Fever
Due to Dehydration
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James E. Hamill M. D.
Address St Agnes Hosp. Date signed 2 June 47
For S. E. J. Lubinski 47
Howard J. Maddeis, M. D.

G52799

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G52799 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be accurately supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D-4
(c) Hospital or Institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 da
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1805 Wilkens Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (MUNDHENK) Charles Mordecai

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-09-1226

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Virginia Mundhenk
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) June 27 1896

8. AGE:	Years	Months	Days	If less than one day
	51	4	24	hr. min.

9. Birthplace Balto Md
(Town, county, and state)
10. Usual Occupation Toolmaker
11. Industry or business Glen L. Martin Co.

FATHER
12. Name Henry Mundhenk
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Bergof
15. Birthplace Germany

16 (a) Informant Mrs Virginia Mundhenk
(b) Address 1805 Wilkens ave.

17 (a) Burial (b) Date thereof 6/25/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director Geo L Beyer Jr.
(b) Address 512 Holland St

19 (a) Filed JUN 28 1947 (b) Registrar Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/24 1947 at 5:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature G. G. Schwaab M.D.
Medical Examiner.
Date signed 6-27-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1931

G52800 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA 19
(e) Length of stay in Baltimore (yrs., mos., or days) DOA 18 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 Hollins Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MABEL PATE or Mamie Pate

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife John Paul Pate

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 28 1903

8. AGE: Years 43 | Months 7 | Days 22 | If less than one day hr. min.

9. Birthplace N. Ch. Carolina (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Walter Hollsman

13. Birthplace N C

MOTHER 14. Maiden Name Louise Sessoms

15. Birthplace N C

16 (a) Informant Mr Henry Pate

(b) Address 700 Hollins St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/24/47 (month) (day) (year)

(c) Cemetery or crematory Family Plot

Location Aberdeen Md

18 (a) Funeral director Geo W Reynolds

(b) Address 1500 Hollins St

19 (a) JUN 23 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/20/47 19 , at 11:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH acute cardiac failure

Due to Hypertensive Cardiovascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R. Davis M.D. Medical Examiner

Date signed 6/24/47

VS 151

WIKARSKI

G52801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. G52801

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light St
(c) Hospital or institution: South Balto Gen. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6736 Youngstown Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Wikarski

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11, 1885

8. AGE: Years	Months	Days	If less than one day
61	11	11	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation self employed
11. Industry or business

FATHER
12. Name George Wikarski
13. Birthplace Poland

MOTHER
14. Maiden Name Margaret
15. Birthplace Poland

16 (a) Informant Joseph Wikarski
(b) Address 630 S Lakewood ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-25-47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location Balto County Md

18 (a) Funeral director George A Weber
(b) Address 705 S. Ann St

19 (a) JUN 23 1947 (Date rec'd by registrar) Thurston for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1947 at 7 49 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 1947, to June 22 1947, and that I last saw h[illegible] alive on June 22 1947.

Immediate cause of death	Duration
Cerebral - vascular accident	12 hrs
Due to Bronchogenic carcinoma	1 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Dillon M. D.
Address So. Balto Gen. Hosp Date signed June 22

VS 150

C52802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered C52802

NH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3n years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 715 New Pittsburgh Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Wesley Lewis

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Mildred
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 26, 1905

8. AGE: Years	Months	Days	If less than one day
41	7	23	hr. min.

9. Birthplace Richmond, Virginia
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Bernard Lewis
13. Birthplace Virginia

MOTHER
14. Maiden Name Virginia Smith
15 Birthplace Virginia

16 (a) Informant Records at Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-23-47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location [illegible]

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 JUN 23 1947 (b) [illegible] Registrar
(Date received by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1947 at 8:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 12 1947 to June 19 1947, and that I last saw h. im alive on June 19 1947.

Immediate cause of death	Duration
Angeloganous Leukemia,	3 wks?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy An absence

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. A. Robinson M. D.
Address Balt. City Hosp. Date signed 6/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C52803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. C52803

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts
(c) Hospital or institution: Union Memorial

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) UNKNOWN

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 105 WENDOVER RD.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) **FULL NAME** CONSTANCE L. MONEY (Constance Lippincott Franchot Money)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Capt HAROLD MONEY 2nd husband Douglas W Franchot

6 (c) If alive, give age UNKNOWN years

7. Birth date of deceased (mo., day, yr.) SEPT 17, 1883

8. AGE: Years 63 | Months 9 | Days 4 | If less than one day ____ hr. ____ min.

9. Birthplace Phila. PENNSYLVANIA (Town, county, and state)

10. Usual Occupation LITERARY CRITIC

11. Industry or business

MOTHER / FATHER

12. Name CRAIG LIPPENCOTT

13. Birthplace Phila. PENN.

14. Maiden Name SALLIE ERER BUCKNELL

15. Birthplace PHILA. PENN

16 (a) Informant Douglas W Franchot Jr.

(b) Address 105 Wendover Rd

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof June 23 1947 (month) (day) (year)

(c) Cemetery or crematory

Location Morris Pa.

18 (a) Funeral director Henry W. Adkins Sons Co

(b) Address McCulloh & Orchard Sts

19 JUN 23 1947 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1947, at 8.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 1947, to June 21 1947, and that I last saw her alive on June 21 1947.

Immediate cause of death	Duration
Arterio-sclerotic hypertensive heart disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Dilated & hypertrophied heart

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph C. Presti, M.D. M. D.

Address Union Mem Hospital Date signed June 22 1947

VS 150

X

G52804 BCH 80930 BALTIMORE CITY HEALTH DEPARTMENT G52804
CERTIFICATE OF DEATH 157E Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Linden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/13/47 8 days

8. AGE: Years | Months | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Charles W Thomas
13. Birthplace Madison Wis.

MOTHER 14. Maiden Name Virginia Linden
15. Birthplace Baltimore Md

16 (a) Informant Chas W Thomas
(b) Address 311 Allen Ave Hopewell Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 23 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Harry A Cunnyngham
(b) Address 47 W Lafayette Ave

19 (a) JUN 23 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/21 1947, at 12:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/13 1947 to 6/21 1947 and that I last saw her alive on 6/21 1947.

Immediate cause of death Cardiac failure
Pulm. edema with hemorrhage
Lobar pneumonia Congenital
Due to Heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy: Congenital heart

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H W Thomas MD
Address St Agnes Date signed 6/22/47

G52805

517366

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54a

G52805

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address.....

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days).....

(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County.....

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 5921 Burgess Ave (If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country.....

3 (a) FULL NAME Rudolph Franz Lovell

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-2122

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Evelyn M.

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.): Dec. 15th 1882

8. AGE: Years 64 | Months 6 | Days 5 | If less than one day ..... hr. ..... min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation.....

11. Industry or business Steamship Co.

FATHER 12. Name Charles Lovell

13. Birthplace Md.

MOTHER 14. Maiden Name Hattie Miller

15. Birthplace Md

16 (a) Informant JOHNS HOPKINS HOSPITAL

(b) Address Records

17 (a) Burial (b) Date thereof 6-24-47 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Moreland PK.

Location Md.

18 (a) Funeral director L. J. Ryck

(b) Address 5305 Harford Rd.

19 (a) JUN 25 1947 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 1947, at 6.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1947, to June 20 1947, and that I last saw h..... alive on ..... 19.....

Immediate cause of death	Duration
Heart failure due to	4 hrs.
Due to Operation for	
Due to Brain Tumor Glioma Frontal Lobe	6 wks.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 6-20-47

Major findings of operation: Glioma frontal Lobe

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide.....

(b) Date of occurrence..... at ..... M

(c) Where did injury occur? ..... (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)

(e) Means of injury.....

23. Signature A. S. Morrow

Address JHH Date signed 6-20-47 M D

G52806 W. F. Sowers
4012 Edmondson Ave.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G52806

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2526 W. Franklin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2526 West Franklin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie L. Bayley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Charles H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1867

8. AGE: Years	Months	Days	If less than one day
79	9	27	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name George Ness
13. Birthplace Md.

MOTHER
14. Maiden Name Hesterina ?
15. Birthplace Md.

16 (a) Informant Mrs. Viola N. Rogers
(b) Address 2526 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/25/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) JUN 23 1947 (Date rec'd by registrar) Huntington Williams, M.D. (b) Address

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22nd 19 47 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/2/47 19 to 6/22/47 19 ; and that I last saw h[illegible] alive on 6/21/47

Immediate cause of death Myocardites

Due to Myocarditis

Due to Arteriosclerosis

Other Conditions None Noted

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. F. Sowers
Address 4012 Edmondson Ave. Date signed 6/23/47

G52807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V131B

G52807 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2006 N. BRUNT ST
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40YRS 4 MONS
(e) Length of stay in Baltimore (yrs., mos., or days) 7 DAYS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2006 N. BRUNT ST
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) **FULL NAME** GEORGE Raymond CURE

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: NEGRO

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Mary Elizabeth CURE

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) Feb 16 1907

8. AGE: Years 40 | Months 4 | Days 25 | If less than one day ____ hr. ____ min.

9. Birthplace BALTO. MD.
(Town, county, and state)

10. Usual Occupation TRUCK DRIVER

11. Industry or business TRUCK DRIVER

FATHER
12. Name GEORGE CURE
13. Birthplace ST MARY COUNTY MD

MOTHER
14. Maiden Name Hattie LYLES
15. Birthplace St. Mary COUNTY MD

16 (a) Informant WIFE OF DECEASED
(b) Address ~~154 Bingham~~ 2006 N BRUNT ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/24/47 (months) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Presstman St

19 (a) Date received by Local Registrar JUN 23 1947 Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/21/47 1947, at 8:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1947 to June 21 1947 and that I last saw him alive on June 5 1947.

Immediate cause of death	Duration
(a) Uremia	
Due to (b) Chr. Glomerulo — Nephritis	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James P. Grant M.D.
Address 15 Mt Division St Date signed 6/21/47

G52808

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V83a

Registered No. G52808

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 930 Bernard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cora Moore

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	N	Widowed

6 (b) Name of husband or wife Rev A. B. Moore
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5 1887

8. AGE: Years	Months	Days	If less than one day
60	1	14	hr. min.

9. Birthplace N. C (Town, county and state)
10. Usual Occupation H. Wife
11. Industry or business

FATHER
12. Name Bob Bradley
13. Birthplace N. C.

MOTHER
14. Maiden Name Jennie Crawford
15. Birthplace N. C.

16 (a) Informant Carrie Pratt
(b) Address 1340 Stockton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/14/47 (month) (day) (year)
(c) Cemetery or crematory Wadesboro
Location Wadesboro, N. C.

18 (a) Funeral director Wm. G. Nelson
(b) Address 1303 Pennsylvania Ave. Huntington Station, Md.

19 (a) JUN 23 1947 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/19 1947 at 6 AM PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/15 1947 to 6/19 1947 and that I last saw h[illegible] alive on 6/19 1947.

Immediate cause of death	Duration
Carbon Monoxide Poisoning	4 hrs
Due to Hypertension	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature James P. Hunt M. D.
Address Provident Hospital Date signed 6/20/47
for J. R. Young by Members of Medical Staff

C52809

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 93D

Registered No. C52809

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert
(c) Hospital or institution: The Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Jarrettsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth Dickey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Leslie A. Dickey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-19-95

8. AGE: Years 52 | Months 2 mo | Days 3 | If less than one day ..... hr. ..... min.

9. Birthplace Illinois (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name T P Biggs
13. Birthplace Kentucky

MOTHER
14. Maiden Name Mollie L Bridgeman
15. Birthplace Illinois

16 (a) Informant Mr. Leslie A Dickey
(b) Address Jarrettsville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 25 47 (month) (day) (year)
(c) Cemetery or crematory Bel Air Memorial Park
Location Bel Air Md

18 (a) Funeral director Martin & Hunt
(b) Address Jarrettsville Md

19 JUN 23 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1947 at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 18 1947 to June 22 47 and that I last saw her alive on June 22 1947

Immediate cause of death: Crushed accident — Duration 5 days

Due to: Ruptured viscera

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H W Williams M. D.

Address Union Memorial Date signed

Dept. X 6-22-47

3 Tr G52810 15

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

G52810
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4701 Delaware Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clifton R Collins, Sr.

3 (b) If veteran, name war: World War I.

3 (c) Social Security Account No. 217-01-9701

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lena E Collins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10, 1896

8. AGE: Years 51 | Months 2 | Days 9 | If less than one day hr. min.

9. Birthplace Lexington, Ky.
(Town, county, and state)

10. Usual Occupation Structural Iron

11. Industry or business

FATHER
12. Name Lewis R. Collins
13. Birthplace Ky

MOTHER
14. Maiden Name Agatha Walden
15. Birthplace Ky

16 (a) Informant Mrs. Lena E Collins
(b) Address 4701 Delaware Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-23-47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Loring Byrne
(b) Address 5005 Liberty Heights Ave

19 (a) Huntington Williams, M.D. (b) Registrar
(Local registrar)
JUN 23 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 1947, at 7:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 6-24-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52811

BALTIMORE CITY HEALTH DEPARTMENT ✓ G52811

CERTIFICATE OF DEATH 46E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: Univ. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 302 E. 25th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Genevieve Calder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Charles Lee Calder
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7, 1881

8. AGE: Years	Months	Days	If less than one day
66	2	15	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Derbyshire
13. Birthplace Philadelphia, Pa.

MOTHER
14. Maiden Name Elmire Gossom
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Crane Calder
(b) Address New York, N. Y.

17 (a) Removal (b) Date thereof 6/25/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Westminster Cem.
Location Phila., Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 23 1947 (Date rec'd by Local Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/22/1947, at 8 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/25/1947 to 6/22/1947 and that I last saw her alive on 6/22/1947.

Immediate cause of death Cardio-Respiratory Failure — Duration

Due to Debilitation

Due to Carcinoma of Ovary & generalized metastases

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Theo. H. Edelson, Jr. M.D.
M. D.

Address Date signed

X

BENYO

G52812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No. G52812

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 951 Rosedale St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 951 Rosedale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Benyo

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Amelia Benyo
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 19. 1858

8. AGE: Years	Months	Days	If less than one day
89	3	2	hr. min.

9. Birthplace Hungary (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Anton Benyo
13. Birthplace Hungary

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Joseph Benyo
(b) Address 951 Rosedale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 24 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director Mrs. John W. Teufel & Son
(b) Address 5311 Edmondson Ave.

19 (a) JUN 23 1947 (b) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1947, at 2.P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 19 47 to June 21 1947. and that I last saw her alive on June 21 1947.

Immediate cause of death Myocardial insufficiency, Chronic Congestive failure — Pulmonary Oedema — Duration 3 Months
Due to Senile Atheroma of Aorta. 1 Week
Other Conditions Prostatic Enlargement (benign) with Urinary retention.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 5901 Edmondson Date signed June 24 1947

VS 150

G52813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No. G52813

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N Carey St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1013 Sterett St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George J Brandt

3 (b) If veteran, name war W | 3 (c) Social Security Account No. None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife Teresa

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19, 1866

8. AGE: Years 81 | Months 1 | Days 3 | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Della Leatherwood
(b) Address Sykesville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/24/47 (month) (day) (year)

(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Hellmann Bros & Lee
(b) Address 412 Fallsway

19 (a) JUN 23 1947 (Date rec'd by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 21 1947 to – 19 , and that I last saw h[illegible] alive on June 21 1947.

Immediate cause of death	Duration
Cardiac Reg. Failure	2 days.
Due to Myocardial weakness	years –
Due to Senility	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles Lamancello M. D.
Address 910 W. Lombard St. Date signed 23 June 1947

X

G52814
AB-111470

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 138

Registered No. G52814

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6days
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 842 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Aby Ray

3 (b) If veteran, name war: W
3 (c) Social Security Account No.:

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: William (D
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8- 1879

8. AGE: Years 68 | Months 8 | Days 14 | If less than one day hr. min.

9. Birthplace Hampstead, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name David Brummel-or- David Babimmel
13. Birthplace Md.

MOTHER 14. Maiden Name Ellen Sellers
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/25/47 (month) (day) (year)
(c) Cemetery or crematory Hampstead Md
Location Carroll Co. Md.

18 (a) Funeral director Tillman & Son
(b) Address 1217 E. Pratt St.

19 JUN 23 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION AM

20. DATE OF DEATH June 22- 1947, at 6.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-16- 1947, to 6-22- 1947, and that I last saw h. alive on 6-22- 1947.

Immediate cause of death Pulmonary Tuberculosis — Duration 1 month

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Sum

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide at M
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Balto City Hospitals M. D.
Address 4940 Eastern Ave. Date signed

X

G52815

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

132

Registered No. G52815

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Providence Drive St
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 36
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Montgomery
(c) City or town Silver Spring
(If outside city or town limits, write RURAL and give town)
(d) Street No. 9121 Old Bladensburg Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Robley Merget

3 (b) If veteran, name war: W
3 (c) Social Security Account No. [redacted]

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Elizabeth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1908

8. AGE: Years 39 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace: Pa.
(Town, county, and state)

10. Usual Occupation: Mechanic

11. Industry or business

FATHER
12. Name: Jacob
13. Birthplace: Pa.

MOTHER
14. Maiden Name: Marie Klinger
15. Birthplace: Pa.

16 (a) Informant
(b) Address

17 (a) Burial, cremation, or removal (b) Date thereof 6/23/47
(month) (day) (year)
(c) Cemetery or crematory: Reading
Location: Reading Pa

18 (a) Funeral director: Hillsdorf & Son Inc
(b) Address: 1219 E Fayette St

19 (a) JUN 23 1947 Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1947, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 21 1947 to June 22 1947 and that I last saw him alive on June 22 1947.

Immediate cause of death: Uremia — Duration

Due to: Malignant hypertension

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

(Date) Hypertensive vascular disease
of autopsy: Hemorrhagic nephritis,

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work?
(Specify type of place)
(e) Means of injury

23. Signature: [illegible]
Address: Univ Hosp Date signed 6-22-47 M. D.

VS 150

G52816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. G52816

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2432 Maryland Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) --
(e) Length of stay in Baltimore (yrs., mos., or days) 20 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2432 Maryland Avenue (If rural give location)
(e) Citizen of foreign country? ------ (Yes or No)
If yes, name country ------

3 (a) FULL NAME Edgar Wellesley Allen

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 237-09-0225

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife: Carolyn L. Allen
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) May 5 1891

8. AGE: Years	Months	Days	If less than one day
56	1	16	hr. min.

9. Birthplace Hardy Co. W. Va., Va. (Town, county, and state)
10. Usual Occupation Pharmacist
11. Industry or business Drug Manufacture

FATHER
12. Name John Parker Allen
13. Birthplace Northumberland Co. Va

MOTHER
14. Maiden Name Sally Hardwick
15. Birthplace Northumberland Co, Va.

16 (a) Informant Mrs Wm Aylip
(b) Address 2432 Maryland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/24/47 (month) (day) (year)
(c) Cemetery or crematory Wm. Oliver's
Location Balto. Md.

18 (a) Funeral director H. W. Meeks and Son
(b) Address 895 N. Eastern Ave Baltimore, Md

19 (a) JUN 23 1947 (Date rec'd by registrar) Registrar

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1947, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1944 19__, to June 21 1947, and that I last saw h__ alive on June 21 1947.

Immediate cause of death: Carcinoma of rectum
Due to: Cardiovascular renal disease

Duration
6 mo
4 yrs

Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation March 1947
Major findings of operation: Carcinoma of rectum
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury —
23. Signature Francis W. Gluck M. D.
Address 718 Park Ave Date signed 6/21/47

G52817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G52817

Md. 90276

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern AVE.

(c) Hospital or institution:
Baltimore City Hospitals 3

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 8 0

(e) Length of stay in Baltimore (yrs., mos., or days) 35 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 101 S. Bond ST. (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Woods, William

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ? 1868

8. AGE: Years	Months	Days	If less than one day
79	?	?	hr. min.

9. Birthplace La. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Thomas Wood

13. Birthplace ?

MOTHER 14. Maiden Name Sarah

15. Birthplace ?

16 (a) Informant Records Balto. City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 23, 47 (month) (day) (year)

(c) Cemetery or crematory Mt Calvery Cem

Location Brooklyn Md

18 (a) Funeral director Elroy B. Wilson

(b) Address 2700 Bleecker ave

19 JUN 23 1947 (b) Huntington Williams M.D. Registrar
(Date received by Registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 - 1947, at 5.10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 18 1944, to June 18 1947, and that I last saw him alive on June 18 - 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Congestive Heart Failure	
Due to Arteriosclerotic Heart Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Same as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Wm. R. Scarborough M. D.

Address Balto City Hosp. Date signed 6-23-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937 ✓

Registered No. G52818

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Ln
(c) Hospital or institution:
Home for the Aged Blind
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Marshall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	M.

6 (b) Name of husband or wife Theodore Marshall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1884

8. AGE: Years	Months	Days	If less than one day
63	1	11	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Horace Mathews
13. Birthplace

MOTHER 14. Maiden Name Henriella Lyons
15. Birthplace

16 (a) Informant Viola Grimes 1st Rel
(b) Address 1200 Valley Ln.

17 (a) Burial (b) Date thereof June 24 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 907 East Biddle St, Balto

19 (a) JUN 23 1947 (b) Huntington Nottingham
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1947, at 6 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch 1 1947, to June 22 1947, and that I last saw her alive on June 21 1947.

Immediate cause of death	Duration
Edema Lungs	2 days
Due to Chronic Myocarditis	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E North ave Date signed 6/23/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 186a

Registered No. G52819

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Severn
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route #1 Box 57
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis A. Meyers

3 (b) If veteran, name war

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Martha H. Meyers Nee- Beyer

6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) November 7, 1871

8. AGE: Years	Months	Days	If less than one day
75	7	15	..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired Painter

11. Industry or business Miller Safe Company -

FATHER
12. Name Louis A. Meyers
13. Birthplace Baltimore

MOTHER
14. Maiden Name Unknown
15. Birthplace U

16 (a) Informant Milton E Meyers (Son)
(b) Address Same as ff.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 25 1947 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge.
Location Washington Blvd & Dorsey Road

18 (a) Funeral director Thomas W. Langston
(b) Address Glen Burnie Md.

19. JUN 23 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1947, at 1 a.m. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 13 1947, to June 22 1947, and that I last saw h.. alive on June 22 1947.

Immediate cause of death	Duration
(a) Cardiac Failure	
Due to (b) Hypertension C.V. Disease	
Due to (c) Lt. Lower Lobe Pneumonia	
Other Conditions Rt. Lt. Pneumonia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence June 13, 1947 at 2 p.m. P.M.
(c) Where did injury occur? Severn - Anne Arundel, Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fell 6 floors

23. Signature Otto E. Schaffer M.D.

Address Md. Gen. Hosp. Date signed Howard J. Mudgett M.D. June 22 1947

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52820

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G52820

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1933 West Baltimore St.
(c) Hospital or institution:
****
(d) Length of stay in hospital or inst. (yrs., mos., or days) ***
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1933 West Baltimore St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME NATHANIEL K. GARDNER

3 (b) If veteran, name war

3 (c) Social Security Account No. 179-01-4669.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Helen H. Gardner.
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) AUG. 14, 1876

8. AGE: Years	Months	Days	If less than one day
70	10	7	..... hr. ..... min.

9. Birthplace Frederick County, Md.
(Town, county, and state)
10. Usual Occupation Launderer
11. Industry or business Penna. Laundry, Philadelphia

FATHER
12. Name William A. Gardner
13. Birthplace Maryland

MOTHER
14. Maiden Name Emaline Kirina
15. Birthplace Maryland

16 (a) Informant Mrs. Helen H. Gardner
(b) Address 1933 West Baltimore St.

17 (a) Burial (b) Date thereof June 24, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount Cemetery
Location Baltimore Maryland

18 (a) Funeral director F. B. Wippert & Son.
(b) Address 1300 Eutaw Place...17

19 JUN 23 1947 Hunting for Millard, Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 st. 1947 at 4:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/13/40 to 6/21 1947, and that I last saw him alive on 6/21 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to Arteriosclerosis	?
Due to Hypertension, Essential	7½ yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurice E. Bozorad M. D.
Address 1905 W. Baltimore Date signed 6/23/47

Dr Traugott 1623 E. North Ave Ex. 6716

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B ~~G52881~~ G52821

~~G52881~~ G52821

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 221 N. High St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 221 N. High St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Wyman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband~~ or wife: Louise Wyman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): About 1875

8. AGE: Years: About 72 | Months | Days | If less than one day: hr. min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER
12. Name: John Wyman
13. Birthplace: Md.

MOTHER
14. Maiden Name
15. Birthplace: Md.

16 (a) Informant: James E. Taylor
(b) Address: 1833 E. North ave.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof: June 24th 1947 (month) (day) (year)
(c) Cemetery or ~~crematory~~: Balto.
Location: " Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 127 St. Paul St.

(c) JUN 23 1947 ~~Registrar~~ Clayton Williams Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1947 at 7:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1946 to June 22 1947 and that I last saw h~~im~~ alive on May 6 1947.

Immediate cause of death: Heart failure

Due to: Mitral - Stenosis

Due to:

Other Conditions: Bronchopneumonia and emphysema of lungs

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration: about 6 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Karl Traugott M. D.

Address: 1623 E. N. Ave Date signed: June 23rd 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~G528222~~ 2211 W. Rogers Ave.

BALTIMORE CITY HEALTH DEPARTMENT ✓ G52822
Registered No.

CERTIFICATE OF DEATH 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 W Rogers Ave
(c) Hospital or institution: Home for Aged of M.E. Church
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 W. Rogers Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH PARKINSON

3 (b) If veteran, name war	3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 5. 1868

8. AGE: Years	Months	Days	If less than one day
79	4	17	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Joel Benson Parkinson
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Hynson
15. Birthplace Baltimore

16 (a) Informant Mamie Fisher
(b) Address 2211 Rogers Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-25-47 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem
Location Balto.

18 (a) Funeral director Wm Col Jno
(b) Address 1217 St Paul St

JUN 28 1947 (Date rec'd by registrar) Thurston Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1947, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947, to June 22 1947, and that I last saw her alive on June 2 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	12 hrs
Due to Arteriosclerosis	10 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Arthur J. Davies M. D.
Address 800 W 33rd St Date signed 6/23/47

VS 150

Dr Stuart Sunday 201 E. 33rd St Re 0339

G52823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G52823

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: Elmhurst Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2218 Lyndhurst ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie M. Austin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Female	White	Married

6 (b) Name of husband or ~~wife~~ James N. Austin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 31st 1877

8. AGE: Years	Months	Days	If less than one day
70	2	2/27	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Dandridge Evans
13. Birthplace Va.

MOTHER
14. Maiden Name Ida E. Joiner
15. Birthplace Va.

16 (a) Informant James N. Austin
(b) Address 2218 Lyndhurst Ave.

17 (a) Removal (b) Date thereof 6/23/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Spring Hill
Location Lynchburg Va.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

19 (a) (b)
(Date filed by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22nd 1947, at 4 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 21 1947, to June 22 1947 and that I last saw her alive on June 22 1947.

Immediate cause of death	Duration
CORONARY THROMBOSIS	10 hrs.
Due to ARTERIOSCLEROSIS	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: Not Done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stuart N. Sunday M. D.
Address 201 East 33rd St. Date signed June 23 1947

G52824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G52824 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 N. Augusta Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 600 N. Augusta Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen B. McGuirk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	Married

6 (b) Name of husband or wife Joseph E. McGuirk
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 8, 1877

8. AGE: Years	Months	Days	If less than one day
69	6	12	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business

FATHER
12. Name Edwin Bryan
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Moore
15. Birthplace Maryland

16 (a) Informant Joseph E. McGuirk
(b) Address 600 N. Augusta Ave.

17 (a) Burial (b) Date thereof 6/24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd.

18 (a) Funeral director Harry H. Witzke
(b) Address 4101 Edmondson Ave.

19 (a) JUN 23 1947 (b)
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/20/47 19 , at 5.30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/13/46 19 , to 6/20/47 19 , and that I last saw h er alive on 6/20/47 19 .

Immediate cause of death coronary thrombosis — Duration 1 day

Due to arterio sclerotic cardio vascular disease

Due to

Other Conditions arterial hypertension
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George A Kripp M. D.
Address 3030 Edmondson ave. Date signed 6/23/47

Huntington Williams, M.D.

X

G52825

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 477

G52825 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNPADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County St Marys
(c) City or town Chaptico
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME Martha A. Davis

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 21, 1886

8. AGE: Years	Months	Days	If less than one day
60	8	2	hr. min.

9. Birthplace St Marys Co. Md (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name William E. Davis
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna Brookbank
15. Birthplace Maryland

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 25 1947 (month) (day) (year)
(c) Cemetery or crematory St. Joseph's
Location Emmanuel Md.

18 (a) Funeral director A. B. Hattingley & Son
(b) Address Leonardtown, Md.

19 (a) JUN 24 1947 (b) Huntingtown Williamsville Md

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1947 at 3:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 12 1947 to June 23 1947 and that I last saw her alive on June 23 1947

Immediate cause of death	Duration
Probable Ca of Lung	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ed P. Smith M.D.
Address Mercy Hospital Date signed 6/23/47

VS 150

G52826

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 8-30a

G52826 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNPADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1620 Division St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 - 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 Division St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William James Steptoe

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Lydia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 29, 1883

8. AGE: Years 64 | Months 1 | Days 22 | If less than one day hr. min.

9. Birthplace Northumberland Co. Va (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name William Steptoe
13. Birthplace Va

MOTHER 14. Maiden Name Adelaide ? ?
15. Birthplace Va

16 (a) Informant Mrs. Irene Amey.
(b) Address 1620 Division St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 24 1947 (month) (day) (year)
(c) Cemetery or crematory Family Lot
Location Oraton Va

18 (a) Funeral director Chas. H. Holland
(b) Address 1651 Druid Hill Ave

JUN 24 1947 (Date filed by registrar) Huntington Williams M.D. (Registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1947, at 12:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 15 1947 to June 21 1947, and that I last saw h[illegible] alive on June 20 1947.

Immediate cause of death cerebral hemorrhage

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. H. Butterworth M. D.

Address 2344 Reisterstown Rd Date signed 6/24/47

G52827

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1214

Registered No. G52827

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 306 W. Franklin St.
(c) Hospital or institution:
Congress Hotel
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 306 W. Franklin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE HUNTER STERNE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Emily Sterne
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20, 1873

8. AGE: Years	Months	Days	If less than one day
74	1	1	hr. min.

9. Birthplace Philadelphia, Pa.
(Town, county, and state)
10. Usual Occupation Captain
11. Industry or business Merchant Marine

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. I. M. Marshall, friend
(b) Address 3110 Gwynn Falls Pkwy.

17 (a) Burial (b) Date thereof 6/24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Mary's Episcopal
Location Pocomoke City, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) JUN 24 1947 (b) Huntington Williams, MD
(Date received by local registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1947, to June 21 1947, and that I last saw him alive on June 21 1947.

Immediate cause of death	Duration
Cardio Vascular Renal Disease	a few years
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H R Johnson M.D.
Address 403 Med Arts Date signed 6/23/47

G52828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G52828

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6421 Edmondson Ave
(c) Hospital or institution: Bon. Sec.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(b) Street No. 6421 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Judith H. Zimmerman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of husband or wife: Albert F. Zimmerman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15 1870

8. AGE: Years 77 | Months 0 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace A. A. Co. Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business —

FATHER
12. Name John G. Hollins
13. Birthplace England

MOTHER
14. Maiden Name Sarah H. Fowler
15. Birthplace Calvert Co. Md.

16 (a) Informant Catherine S. Hollins
(b) Address 2434 Edmondson Ave

17 (a) Burial (b) Date thereof 6/25/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

JUN 24 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/21 1947, at 5:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic CV disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. Medical Examiner
Date signed 6/23/47

G52829

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54a

G52829

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2452 Eutaw Pl. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dr. Harry Goldberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Bertha K.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-18-85

8. AGE: Years	Months	Days	If less than one day
61	6	5	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Physician
11. Industry or business

FATHER
12. Name Myer
13. Birthplace Russia

MOTHER
14. Maiden Name Ida
15. Birthplace Russia

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 24 47 (month) (day) (year)
(c) Cemetery or crematory Holum Washington Blvd
Location Washington Blvd

18 (a) Funeral directors Sol Kevruan & Bro
(b) Address 1126 W Mertle ave

19 (a) JUN 24 1947 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1947 at 12 05 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 9 1947 to Jun 23 1947 and that I last saw him alive on June 23 1947.

Immediate cause of death	Duration
Intracranial hemorrhage	2 hr.
Due to Brain Tumor.	1 month
Due to	
Other Conditions Bronchopneumonia Arteriosclerosis. (Include pregnancy within 3 months of death)	

Date of operation June 11, 1947
Major findings of operation: Left-cortical glioma, Rt hemisphere.
of autopsy: Refused.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Arthur M. Lang M. D.
Address Johns Hopkins Hosp. Date signed 6/23/47

X.

G52830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G52830 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3612 Fords Lane.
(c) Hospital or institution: 27-20
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life time

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3612 Fords Lane (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HILDA ROSENHEIM STRAUSS.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband ~~or wife~~ Leon Strauss.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 30, 1886.

8. AGE: Years	Months	Days	If less than one day
61	1	24	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Benjamin Rosenheim,
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Sadie Rosenstock,
15. Birthplace Balto. Md.

16 (a) Informant Mr. Leon Strauss,
(b) Address 3612 Fords Lane.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/24/47. (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Baltimore, Md.

18 (a) Funeral director [illegible]
(b) Address 1902 Eutaw Place.

19 (1) 6 24 1947 (b) Huntington Williams M.D. Registrar
(Date received in this office)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23rd, 1947, at PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1933 to June 23 1947, and that I last saw h[illegible] alive on June 23 1947

Immediate cause of death Carcinoma of cervix — Duration 4 mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address 1720 Eutaw Place. Date signed 6/24/47

X.

G52831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G52831

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 802 W. North Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 → 2
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 802 W. North Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME BELLE LEVI.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Jacob Levi
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26, 1865.

8. AGE:	Years	Months	Days	If less than one day
	81	5	28	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None.
11. Industry or business

FATHER
12. Name Philip Bergman,
13. Birthplace Germany.

MOTHER
14. Maiden Name Henrietta Stein,
15. Birthplace Germany.

16 (a) Informant Mr. Philip Levi,
(b) Address 118 N. Liberty St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/ /47. (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Baltimore, Md.

18 (a) Funeral director Harris Sons Funeral Home
(b) Address 1902 Eutaw Place.

19 JUN 24 1947 (b) Huntington Williams M.D.
(Date received by Registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23rd. 1947, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1947, to June 23 1947, and that I last saw h[illegible] alive on June 20 1947.

Immediate cause of death	Duration
Coronary thrombosis	1 day
Due to Coronary artery disease	2 mos
Due to Arterio sclerosis	2 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature I. Frederick Levy M. D.
Address Temple Garden Apts Date signed 6/23/47

G52832

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

Registered No. G52832

NH 111548

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 38 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1519 N. Carey St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Blanche Pitts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Married

6 (b) Name of husband or wife John T.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 14, 1889

8. AGE: Years	Months	Days	If less than one day
57	6	9	hr. min.

9. Birthplace Washington D. C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Edgar Campbell (dead)
13. Birthplace New York

MOTHER
14. Maiden Name Emma L. Davenport
15 Birthplace New York

16 (a) Informant Records at Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof June 24 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Carlton M. Park
Location Arbutus

18 (a) Funeral director Wm Brooks
(b) Address 1639 N. Carey St

19 (a) JUN 24 1947 (b) Huntington Williams, M.D.
(Date received by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1947, at 8:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 1947 to June 23 1947 and that I last saw her alive on June 23 1947

Immediate cause of death Acute Myocardial failure following operation — Duration 2 hrs.

Due to

Due to

Other Conditions Acute Cholecystitis & cholelithiasis

(Include pregnancy within 3 months of death)

Date of operation June 21, 1947

Major findings of operation Acute Gangrenous Cholecystitis

of autopsy Absent

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurice M. Levy M. D.
Address Baltimore City Hosps. Date signed 6-23-47

C52833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

C52833 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1722 Abbottston St.
(c) Hospital or institution: 9-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 19 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1722 Abbottston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Wanda M. Grammer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife F. Melvin Grammer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 20th, 1908

8. AGE: Years	Months	Days	If less than one day
38	8	3	hr. min.

9. Birthplace Ind. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Andrew J. Childers
13. Birthplace Ind.

MOTHER
14. Maiden Name Nora M. Metcalf
15. Birthplace Ind.

16 (a) Informant Mr. F. Melvin Grammer
(b) Address 1722 Abbottston St.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 6/25/47 (month) (day) (year)
(c) Cemetery or crematory Moreland
Location Taylor Ave.

18 (a) Funeral director Lasasha Funeral Home
(b) Address 7401 Belair Road

19 (a) (b) (Name of city or cemetery) Huntington Williams M.D.

JUN 24 1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23rd 1947 at 12 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 1947 to June 23 1947, and that I last saw h[illegible] alive on June 22 1947.

Immediate cause of death	Duration
Cerebrum Illness	8 mo
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature F D a Stearns M. D.
Address 2918 Harford Av Date signed 6 26 47

X

G52834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G52834

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1141 Shields Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1141 Shields Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Henry Simms

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-15-1895

8. AGE: Years	Months	Days	If less than one day
52	5	8	hr. min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER 12. Name Frank Simms

13. Birthplace Md

MOTHER 14. Maiden Name Jennie Johnson

15. Birthplace Md

16 (a) Informant Mary Fisher

(b) Address 1141 Shields Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 27 47 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem

Location Baltimore Md

18 (a) Funeral director William A Jackson

(b) Address 916 Penna ave

JUN 24 1947 (Date received by Registrar) Huntington Williams, M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1947, at 8 45 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardio-vascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.

Date signed 6/23/47

G52835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 183

G52835

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dda
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 707 "Y" alley
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adele Roberta (ROBINSON)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	SINGLE.

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 7-30-1925

8. AGE: Years	Months	Days	If less than one day
21 22	10	21	hr. min.

9. Birthplace Dorchester Md
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Thomas Robinson
13. Birthplace Md

MOTHER
14. Maiden Name Blanch Green
15. Birthplace Md

16 (a) Informant Thomas Robinson
(b) Address 130 S. High St

17 (a) Burial (b) Date thereof 6 25 47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 916 Pennsylvania ave

19 JUN 24 1947 (a) Huntington Williams M.D.
(Entered by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 1947 at 7.25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation
Due to Drowning
Other Conditions Had been drinking intoxicating liquor
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-20-47 at 6:00 P.M.(?)
(b) Where did injury occur? Pier #6 - Patapsco
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? no
(d) Means of injury Found drowned

23. Signature Howard J. Weaver M.D.
Medical Examiner.
Date signed 6-21-47

X

G52836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G52836 Registered No. 1222

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 409 N. Pine st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilber Evans

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
m	c	married

6 (b) Name of husband or wife Mrs. Annie Evans
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 12 1913

8. AGE: Years	Months	Days	If less than one day
33 34	8	10	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation laborer
11. Industry or business

FATHER
12. Name Isiah Evans
13. Birthplace Va

MOTHER
14. Maiden Name Nannie Quales
15. Birthplace Va.

16 (a) Informant Mrs Annie Evans
(b) Address 409 N. Pine st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 26 47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director Williams & Jackson
(b) Address 916 Pennsylvania ave

19 (a) Date received by registrar JUN 24 1947 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-22 1947, at 8:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-22 1947 to 6-22 1947 and that I last saw h.im alive on 6-22 1947.

Immediate cause of death	Duration
cardio-vascular collapse	
Due to Intestinal Obst	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James V. Minor M. D.
Address Mercy Hosp Date signed 6/22/47

Minor Jr.

G52837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 171a

Registered No. G52837

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Baltimore City Hospital 26-10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3308- E. Baltimore St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME MARY A. RANDALL

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Chas. B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13-1869

8. AGE: Years	Months	Days	If less than one day
78 79	2	9	....hr. ....min.

9. Birthplace Balto.Md.
(Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name Charles Nuthall
13. Birthplace Balto.Co.Md.

MOTHER
14. Maiden Name Elizabeth Sprague
15. Birthplace Balto.Co.Md.

16 (a) Informant Charles B. Randall
(b) Address 3308- E. Balto. St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 25-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director John J. Gadsden
(b) Address 3000 E. Balto. St.

19 (a) JUN 24 1947 (Date received by registrar) (b) Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22, 1947, at 1.32 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull & intra-cranial Hemorrhage

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 26/10
(a) Date of injury 6-20-47 at about 8 P.M.
(b) Where did injury occur? Balto. & Clinton St. Balto.Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian-struck by st. car

23. Signature Earl L. Ryder M.D.
Medical Examiner.
Date signed 6-23-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G52838

183

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 830 Tessier Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES WELDON COOK

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1930

8. AGE: Years 16 17 | Months 8 | Days 19 | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Charles Cook
13. Birthplace North Carolina

MOTHER 14. Maiden Name Sophie Hunter
15. Birthplace North Carolina

16 (a) Informant Sophie Cook
(b) Address 830 Tessier St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-26-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 JUN 24 1947 (Date received by Registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23, 1947, at 12.30 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Drowning

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 24/2
(a) Date of injury 6-23-47 at 12 p. M.
(b) Where did injury occur? Harbor-335 Key Highway Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Found drowned

23. Signature Howard J. Williams M.D. Medical Examiner.
Date signed 6-23-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52839

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓167

G52839 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please correct age is especially important. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 17-
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 512 Druid Hill Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES RUSSELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1925

8. AGE: Years 22 | Months | Days | If less than one day hr. min.

9. Birthplace Wilmington, N. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Henry Russell
13. Birthplace North Carolina

MOTHER
14. Maiden Name Flora Addison
15. Birthplace North Carolina

16 (a) Informant Willie Jackson
(b) Address 1136 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-25-47 (month) (day) (year)
(c) Cemetery or crematory Wilmington
Location North Carolina

18 (a) Funeral director Adolphus Halsted
(b) Address 918 Druid Hill Ave

19 JUN 24 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS. 181

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22, 1947, at 1.30 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒ undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemorrhage from Stab-wounds of right lung and aortic artery.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-22-47 at about 12.30 a. M. outside- 523 Orchard St.
(b) Where did injury occur? Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Sharp instrument

23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 6-23-47

G52840

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1176

Registered No. G52840

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hosp. 28
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 Days
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4518 Pentwurst Ave
(If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME ISAAC P. MILLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mary

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 10 1873

8. AGE: Years 74 | Months 2 | Days 12 | If less than one day ..... hr. ..... min.

9. Birthplace Johnsville Md.
(Town, county, and state)

10. Usual Occupation Retired Policeman

11. Industry or business Balto City Police Dept

FATHER
12. Name Christian Miller
13. Birthplace Unknown

MOTHER
14. Maiden Name Martha Gosnell
15. Birthplace Baltimore Md.

16 (a) Informant Mary M. Miller
(b) Address 4518 Pentwurst Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 26 1947 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Harry R. Thuneardt
(b) Address 4204 Ridgewood Ave

19 (a) ..... (b) Date received by registrar JUN 24 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/22 1947, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/10 1947 to 6/22 1947 and that I last saw him alive on 6/22 1947.

Immediate cause of death	Duration
Cardiac resp. failure	
Due to A.C.V.D. Ectopic auricular fibrillation, cardiac	
Due to failure grade IV pulmonary edema	
Other Conditions congestion, perforated duodenal ulcer.	

(Include pregnancy within 3 months of death)

Date of operation 6/10/47 - 6/22/47

Major findings of operation: perforated duodenal ulcer-evisceration

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature H. L. Conrad M. D.

Address Univ. Hosp. Date signed 6/23/47

JUN 24 1947

G52841

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. G52841

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Ellwood Ave
(c) Hospital or institution:
St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-
(e) Length of stay in Baltimore (yrs., mos., or days) 23

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 273 S. Ellwood Ave (If rural give location)
(e) Citizen of foreign country? YES (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE J. GAITANES

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
No	215-07-4473	Male	White	Widowed

6 (b) Name of husband or wife Machella Kacanis Gaitanes
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) MAR. 21 1884

8. AGE: Years	Months	Days	If less than one day
63	3	—	hr. min.

9. Birthplace Chios Greece (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Gaitanes
13. Birthplace Chios, Greece

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Stella Pangalis
(b) Address 273 S. Ellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/24/47 (month) (day) (year)
(c) Cemetery or crematory Greek Orthodox Evangelismos
Location

18 (a) Funeral director Geo. J. Agnew Funeral Home Inc.
(b) Address 118 W. Mt. Royal Ave

JUN 24 1947 (Date received) Huntington Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/21 1947, at 9:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/5 1947 to 6/21 1947 and that I last saw h[illegible] alive on 6/21 1947

Immediate cause of death	Duration
Cardiac failure	
Coronary Sclerosis	
Due to Myocardial failure	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Date signed 6/22/47

B52842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G52842

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 607 S. Lakewood Ave.
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 607 S. Lakewood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mollie Bronikowski (Brown)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Henry J. Bronikowski
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Aug. 24 - 1895

8. AGE: Years	Months	Days	If less than one day
51	9	27	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Kaworski
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Kibanski
15. Birthplace Poland

16 (a) Informant Mrs. Bronikowski
(b) Address 607 S. Lakewood Ave.

17 (a) Burial (b) Date thereof June 23-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location German Hill Rd.

18 (a) Funeral director John B. Connelly
(b) Address 418 Eastern Ave. Conn 21

19 (a) (Date rec'd by registrar) (b) Huntington Williamsport

JUN 24 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1947, at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19

Immediate cause of death	Duration
Cerebral Hemorrhage.	Instant
Due to Hypertension	3 yrs.
Due to Arteriosclerosis	3 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John V. Zagerski M. D.
Address 1802 Eastern Ave. Date signed 6-23-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 73a

G52843 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland.
(b) Street address Roland & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 - 6 - 3 - 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5620 Pilgrim Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Annie M. Fowble

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Frederic S.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 5-1859

8. AGE: Years: 87 | Months: 10 | Days: 18 | If less than one day: hr. min.

9. Birthplace Manchester, Md. (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name William Buckingham
13. Birthplace Md.

MOTHER
14. Maiden Name Homer
15. Birthplace Md.

16 (a) Informant Mrs. Guy Garman
(b) Address 5620 Pilgrim Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-26-47 (month) (day) (year)
(c) Cemetery or crematory Emory Chapel
Location Md.

18 (a) Funeral director Leonard J. Leyh
(b) Address 5305 Harford Road.

19 (a) [illegible] (Date rec'd by Registrar) (b) Huntingtown, Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23, 1947, at 6.05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 20, 1947, to June 23 1947, and that I last saw her alive on June 23 1947.

Immediate cause of death Cardiac Failure — Duration

Due to Auricular Fibrillation

Due to Generalized Arteriosclerosis

Other Conditions Pernicious Anemia, Senility

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address Emory Hospital Date signed 6-28-47 M.D.

97

G52844

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G52844

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH,
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto Gen. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dbt
(e) Length of stay in Baltimore (yrs., mos., or days) 2 M

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2310 Southern Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James A.G. Moran Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Marie Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 13 - 1876

8. AGE: Years 71 | Months 3 | Days 10 | If less than one day ____hr. ____min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Stationery & mg.

11. Industry or business Nail Enamel - Plate

FATHER
12. Name Richard T. Moran
13. Birthplace Md.

MOTHER
14. Maiden Name Alice
15. Birthplace Md.

16 (a) Informant Mr. James Moran, Jr.
(b) Address 2810 Echodale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-27-47 (month) (day) (year)

(c) Cemetery or crematory Moreland.
Location Balto.

18 (a) Funeral director Leonard J. Keck
(b) Address 5305 Harford Road.

19 (a) 6 27 1947 (Date rec'd by registrar) (b) [illegible] for Williams M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1947, at 4:15 P.M.

21. I certify that I took charge of the remains described above, held an Insp & Org thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature William S. Helbrecht M.D.
Medical Examiner.

Date signed June 23, 1947

G52845

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. G52845

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 928 McDonough St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH McKENNA (McKINNON)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): ? ? 1921

8. AGE: Years 16 | Months | Days | If less than one day hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name James McKinnon
13. Birthplace N.C.

MOTHER
14. Maiden Name Lillie Bowlden
15. Birthplace Va.

16 (a) Informant Herbert Bowlden
(b) Address 1809 E Chase St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 24/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A.A. County

18 (a) Funeral director Mrs Robt A Elliott Dft
(b) Address 1029 N. Caroline St

19 JUN 24 1947 (b) Huntington Williams, M.D. Registrar
(Registered by local registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21, 1947 4 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet-wound of base of skull
Intracranial hemorrhage
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6/21/47 3:30 A. M.
(b) Where did injury occur Carolina & Preston Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
Means of injury Firearms = Shotgun

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 6/21/47

C52846

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. C52846

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 904 McDonough St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Margaret Fitts

3 (b) If veteran, name war.....
3 (c) Social Security Account No.....

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lowe Fitts

6 (c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.) 6-28-94

8. AGE: Years 53 | Months - | Days 24 | If less than one day .....hr. .....min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation.....

11. Industry or Business.....

FATHER — 12. Name Gregory Gordon
13. Birthplace Va

MOTHER — 14. Maiden Name Edna Eellem
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof June 24/47 (month) (day) (year)
(c) Cemetery or crematory.....
Location: Drakes Branch Virginia

18 (a) Funeral director Mrs. Lott A. Elliott Sr.
(b) Address 1129 N. Caroline St.

19 JUN 24 1947 (Date received by Local Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21, 1947, at 2 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 4 1947, to June 21 1947, and that I last saw h[illegible] alive on June 20 1947.

	Duration
Immediate cause of death: Cerebral hemorrhage	1 hr.
Due to: Carcinoma head of pancreas	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 6/10/47
Major findings of operation: Ca of pancreas
of autopsy: Same

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Henry K. Bahnson M.D.
Address JHH Date signed 6/21/47

Bahnson X

G52847

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47a

Registered No. G52847

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 804 S. Dean St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 - 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 804 S. Dean St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT R. SCHUMANN

3 (b) If veteran, name war ---

3 (c) Social Security Account No. 213-07-9485

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anna M. Schumann
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1890

8. AGE: Years	Months	Days	If less than one day
57	5	22	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Crane Operator
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Frank F. Schumann
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Schlerick
15. Birthplace Germany

16 (a) Informant Anna M. Schumann (Wife)
(b) Address 804 S. Dean St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 26, 47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville, Balto. Co., Md.

18 (a) Funeral director Charles L. Zirkle
(b) Address 3605 Fait Ave.

19 (a) Date received JUN 24 1947 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23, 1947, at 10:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 23 1946 to June 23 1947, and that I last saw h[illegible] alive on June 23 1947.

Immediate cause of death Acute Cardiac Failure — Duration

Due to Coronary Artery Disease

Due to

Other Conditions Carcinoma of Larynx

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward A. Flanagan Jr
Address 3503 Fait Ave Date signed 6-23-47 M. D.

X

HOPKINS

G52848

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G52848

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1101 Booth St.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1101 Booth St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Arthur Hopkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	C	Widower

6 (b) Name of husband or wife Eliza Davis Hopkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27, 1872

8. AGE: Years	Months	Days	If less than one day
74	11	24	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Joseph Hopkins
13. Birthplace Md

MOTHER
14. Maiden Name Victoria Butler
15. Birthplace Annapolis, Md.

16 (a) Informant Agnes Young
(b) Address 1103 Booth St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-25-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 3221 Schroeder St.

19 JUN 24 1947 (Date received by registrar) Huntington Williams, M.D. (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/21 1947 at 7P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 0 1947 to June 21 1947 and that I last saw him alive on 6/21 1947.

Immediate cause of death Arteriosclerosis Fever — Duration 16 D

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
Means of injury

23. Signature B J Hatcher M.D.
Address 1 r r s Date signed 6/24/47

C52849

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 767

Registered No. C52849

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4008 Oakford Ave.
(c) Hospital or institution:
15 → 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4008 Oakford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: REBECCA J. MERRYMAN

3 (b) If veteran, name war: -

3 (c) Social Security Account No. -

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Robert Merryman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30, 1858

8. AGE: Years 88 | Months 10 | Days 22 | If less than one day ... hr. ... min.

9. Birthplace: Sandy Hook, Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: A. Barnhart
13. Birthplace: Sandy Hook, Md.

MOTHER
14. Maiden Name: Amanda Hurdle
15. Birthplace: Md.

16 (a) Informant: Mrs. Alyce M. Carter
(b) Address: 4008 Oakford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/25/47 (month) (day) (year)
(c) Cemetery or crematory: Lorraine Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) JUN 24 1947 (b) (Date received by Registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22, 1947, at 10:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1947 to June 22 1947, and that I last saw h[illegible] alive on June 22 1947.

Immediate cause of death	Duration
Blood Dyscrasia	6 Mos
Coming Bleeding Tongue	
Rectum, Pain into Stom	
Due to Senility & Carcinoma	
Intestines	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 710 Medical Arts Bldg Date signed 6/23/47

X

G52850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G52850 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Cator Avenue
(c) Hospital or institution: Jenkins Memorial Hospital 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 127 E. West Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ida Adams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1859

8. AGE: Years	Months	Days	If less than one day
88	7	8	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John C. Adams
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Anna C. Nicklon
15. Birthplace Baltimore Md

16 (a) Informant Mr. Thorn Peters
(b) Address 105 Warren Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 23/37 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet
Location 2330 Frederick Rd

18 (a) Funeral director Wagner Funeral Home
(b) Address 1216 S. Charles St.

19 (Local Registrar) JUN 24 1937 (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/21/37 1937, at 7:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death	Duration
Cardiac Failure - Angina Pectoris - Hypertension Due to C.V.D.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. N. Mink M.D.
M. D.
Address Date signed

VS 150

FATUNIA.

C52851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. C52851

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 14-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) D O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 338 Presstman Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FATUNIA VALENTINE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1910

8. AGE: Years 37 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Elvin Driggs

13. Birthplace Gathemsburg Va

MOTHER 14. Maiden Name Maggie Price

15. Birthplace Northumberland Co Va

16 (a) Informant John C Driggs

(b) Address 2100 N. Fulton Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof June 24-47 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial Park

Location Balto. Co-Md.

18 (a) Funeral director Wm. Geo. Holland

(b) Address 1631 Druid Hill Ave

19 (a) JUN 24 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23, 1947, at 8.30 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wounds of brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 6-23-47 at about 8 a. M.

(b) Where did injury occur? Dellman & Roland Ave. Balto. Md.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Firearms

23. Signature Earle Ryan M.D.
Medical Examiner.

Date signed 6-24-47

C52852 C52852-146 1transcript BALTIMORE CITY HEALTH DEPARTMENT C52852

CERTIFICATE OF DEATH ✓ 8/a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 1/2yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1505 Lamont Ave zone 13
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel Foster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7- 1920

8. AGE: Years	Months	Days	If less than one day
26	6	15	hr. min.

9. Birthplace Ga.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Benjamin Perry
13. Birthplace ?

MOTHER
14. Maiden Name Clara Morboley
15. Birthplace ?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof 6/26/47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Md.

18 (a) Funeral director Wm. George & Wolland
(b) Address 6[illegible] Fremont Ave.

19 JUN 24 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22- 1947 at 1:55AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-15- 1947, to 6-22- 1947, and that I last saw h[illegible] alive on 6-22 1947.

Immediate cause of death	Duration
Septicemia due To	
Due to Staphylococcus Albus Meningitis due To	12 days
Due to Staphylococcus Albus	12 Days
Other Conditions Endocarditis Lenta	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Laurence Lee Jr. M. D.
Address Balt. City Hosp. Date signed 6-23-47

X

G52853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

G52853 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 da
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1507 Madison Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Ruby HAMLET
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Negro	MARRIED

6 (b) Name of husband or wife Allie HAMLET
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec. 7 1914

8. AGE: Years	Months	Days	If less than one day
32	6	16	hr. min.

9. Birthplace Roxboro N. C. (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER 12. Name Richard Crowder
13. Birthplace N. Carolina

MOTHER 14. Maiden Name unknown
15. Birthplace ?

16 (a) Informant Allie HAMLET
(b) Address 1507 MADISON AVE

17 (a) (Burial, cremation, or removal) (b) Date thereof 6-24-47 (month) (day) (year)
(c) Cemetery or crematory Family Lot
Location Danville Va.

18 (a) Funeral director Mt. Geo. W. Holland
(b) Address 1631 Druid Hill ave.

19 JUN 24 1947 (Date rec'd by registrar) (b) Huntington Hollins Funeral Home

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1947, at 12 01 AM

21. I certify that death occurred on the date above stated; that I attended deceased from MAY 14 1947 to June 23 1947 and that I last saw her alive on June 22 1947

Immediate cause of death	Duration
Carcinomatosis secondary to Uterine	2
Due to Puerperal Hemorrhage	2
Due to	over
Other Conditions Pleurisy (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 707 N Carey Date signed 6/24/47

VS 150

G52854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G52854 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3715 Fourth St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Girlomo) John Trotta

3 (b) If veteran, name war: no.
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife: Carola Trotta
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/18/1874

8. AGE: Years	Months	Days	If less than one day
72	1/10	3/15	hr. min.

9. Birthplace Balto Italy (Town, county, and state)
10. Usual Occupation [redacted]
11. Industry or business

FATHER
12. Name Benjamin Trotta
13. Birthplace Italy

MOTHER
14. Maiden Name Magliano
15. Birthplace Italy

16 (a) Informant Carmela. Trotta
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 26 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road
18 (a) Funeral director Rendell & Kippel
(b)
19 (a) JUN 24 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/21 1947; at 9:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/17 1947 to 6/21 1947, and that I last saw h[illegible] alive on 6/21 1947.

Immediate cause of death: Cardiac Failure — Duration

Due to: Coronary

Due to:

Other Conditions: Femoral Hernia
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [redacted] M.D.
Address Mercy Date signed 6/21/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52855 new. Cathedral

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G52855 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2691 St Benedict St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2691 St Benedict St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Dick

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
W.	none	Female	White	Widow

6 (b) Name of husband or wife John Dick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22 1873

8. AGE: Years	Months	Days	If less than one day
74	4	2	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Jennie J. Eckert
(b) Address 2691 Benedict St
17. (a) Burial, cremation, or removal Green Mount (b) Date thereof 6/25/47 (month) (day) (year)
(c) Cemetery or crematory Green Mount Cem
Location Baltimore Md
18 (a) Funeral director Wilson & Son
(b) Address 1214 E Fayette St
19 (a) Filed (b) Huntington Williams, Md Registrar
JUN 24 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1947, at 5 30 M
21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947, to June 23 1947 and that I last saw h alive on June 23 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 3 days
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Harry Glassman M. D.
Address 2687 Mt Royal Ave Date signed

VS 150

G52856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G52856 Registered No. 131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1202 Sabina Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1202 Sabina Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vera G Palmer

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Chester A Palmer Sr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12, 1897

8. AGE: Years	Months	Days	If less than one day
49	9	10	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Duffenghame
13. Birthplace Md

MOTHER
14. Maiden Name Florence Wonder
15. Birthplace Md

16 (a) Informant Chester A Palmer Sr
(b) Address 202 Sabina Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/26/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Catonsville Md

18 (a) Funeral director Chas H Ford Sr
(b) Address Balto Md

19 (a) JUN 24 1947 (Date rec'd by registrar) Huntington Williams Md Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1947, at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1946, to June 22 1947, and that I last saw h alive on June 22 1947.

Immediate cause of death	Duration
Cardiac decompensation	6 mos
Due to Carbo-vascular-renal disease	1 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address 846 W 36 St Date signed 6/27/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 93E

Registered No. G52857

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Southern Hotel-Light & Redwood Sts.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 11 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Norfolk (If outside city or town limits, write RURAL and give town)
(d) Street No. 5710 Hugo St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Olav H. Johannesen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married.

6 (b) Name of husband or wife Alice Evenson

6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) Dec. 16, 1907

8. AGE: Years	Months	Days	If less than one day
39 38	6	8	hr. min.

9. Birthplace Bergen, Norway (Town, county, and state)

10. Usual Occupation Chief Mate

11. Industry or business U.S. Merchant Marine

FATHER
12. Name Hans Johannesen
13. Birthplace Norway

MOTHER
14. Maiden Name ?
15. Birthplace Norway

16 (a) Informant Mrs. Alice E. Johannesen
(b) Address 5710 Hugo St. Norfolk, Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-26-47 (month) (day) (year)
(c) Cemetery or crematory
Location Norfolk, Va.

18 (a) Funeral director John O Mitchell Post 107
(b) Address 1900 Eutaw Place.

19 (a) JUN 24 1947 (Received by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24, 1947, at 12.45 P.M.

21. I certify that I took charge of the remains described above, held an insp. & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Congestive Cardiac Failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mitchell M.D. Medical Examiner.
Date signed 6-24-47

X

G52858

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 122a

Registered No. G52858

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Rural - Langhorne Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 201 Second Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bernard Doyle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Mary E. 1889

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15 1890

8. AGE: Years	Months	Days	If less than one day
57 56	2	6	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Stationary Engineer

11. Industry or business

FATHER 12. Name Oscar Doyle

13. Birthplace Md.

MOTHER 14. Maiden Name Annie Harris

15. Birthplace Md.

16 (a) Informant Mrs. Mary Doyle

(b) Address Lansdowne Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-25-47 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director George A Fearby

(b) Address Eutaw Place & Fayette St.

19 JUN 24 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/21 1947, at 12 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Post Operative Ventral Hernia

Due to

Other Conditions Hypertensive C.V. Disease (Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature C. J. Sulivan M.D. Medical Examiner.

Date signed 6/21/47

X

G52859

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G52859 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Hebbville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rices Lanes R.F.D. 5
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose E. Harris Burley

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Henry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 5, 1868

8. AGE: Years 79 | Months 2 | Days 19 | If less than one day: hr. min.

9. Birthplace: Somers Pt. N. J.
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: William Harris
13. Birthplace: Camden N. J.

MOTHER
14. Maiden Name: Selina King
15. Birthplace: Nova Scotia

16 (a) Informant: Alfred J. Fry Jr.
(b) Address: 6501 Reistertown Rd.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 6/25/47 (month) (day) (year)
(c) Cemetery or crematory
Location: Mays Landing N. J.

18 (a) Funeral director: Wm. J. Tickner & Sons
(b) Address: North & Pa. Aves.

(a) JUN 25 1947 (Date received by Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/24 1947, at 3 15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/23 1947, to 6/24 1947, and that I last saw HER alive on 6/24 1947.

	Duration
Immediate cause of death: CEREBRAL HEMORRHAGE	1 DAY
Due to: HYPERTENSIVE CARDIO-VASCULAR DISEASE	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles W. Stewart, Jr. M. D.
Address MD. GEN. HOSP. Date signed 6/24/47

G52860

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G52860 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John Street
(c) Hospital or institution:
Hospital For The Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D
(e) Length of stay in Baltimore (yrs., mos., or days) Not Known

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3614 Chatham Road
(If rural give location)
(e) Citizen of foreign country? Not Known (Yes or No)
If yes, name country

3 (a) FULL NAME Rose [redacted] BERKOWITZ (BURKE)

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife [redacted]

6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) [redacted] 1882

8. AGE: Years 65 [redacted] Months 10 Days 0.8 If less than one day ____ hr. ____ min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation Home Wife

11. Industry or business

FATHER
12. Name Gershon Cohen
13. Birthplace Russia

MOTHER
14. Maiden Name Eva Friedman
15. Birthplace Russia

16 (a) Informant Henry G Burke
(b) Address 1820 Eutaw place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-25-47 (month) (day) (year)

(c) Cemetery or crematory Hebrew Herring Run
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 1409 E Balto St

19 JUN 25 1947 (Date received by Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-24 1947, at 7:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 23 1947, to June 24 1947, and that I last saw her alive on June 24 1947.

Immediate cause of death ..... Duration

Cardiac failure

Due to Coronary thrombosis

Due to Arteriosclerosis coronary disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Mark F. Hansen M. D.
Address 1309 John St Date signed 6-24-47

X

G52861

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G52861
Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2806 Mayfield Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) Some

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2806 Mayfield Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph F. Jachowski

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Late Helena
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feby 6, 1880

8. AGE: Years	Months	Days	If less than one day
67.	4	17	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Gen'l Electric Co.

FATHER
12. Name Julius Jachowski
13. Birthplace Germany

MOTHER
14. Maiden Name Makowski
15. Birthplace Germany

16 (a) Informant
(b) Address 2806 Mayfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/26/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location 4439 Belair Road

18 (a) Funeral director John J. Corona & Son
(b) Address 1103 Fallsway Street

19 (a) June 25 1947 (Date received by local reg.) (b) Huntington Williams, M.D.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23rd 1947, at 10.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1st 1943, to June 23rd 1947, and that I last saw h alive on June 23rd 1947.

	Duration
Immediate cause of death Coronary occlusion	2 months
Due to Arteriosclerosis	4 yrs.
Due to Chr. Nephritis	4 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. J. McDermott
Address 1136 Poplar Grove St Date signed M. 6 D. 25/47

G52862

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G52862

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 570 Overbrook Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Dawood Norris Kelly Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Lilly Woodall Kelly

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13 1874

8. AGE: Years 72 73 | Months 11 | Days 20 10 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Furniture salesman

11. Industry or business

FATHER
12. Name Thomas W. Kelly
13. Birthplace Maryland

MOTHER
14. Maiden Name Louisa Mae Scott
15. Birthplace Maryland

16 (a) Informant Lilly Woodall Kelly
(b) Address 570 Overbrook Rd City

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6/29/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 JUN 25 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1947, at 11 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 21 1947 to June 23 1947 and that I last saw him alive on June 23 1947.

Immediate cause of death: Cardiac decompensation — Duration: 3 Days
~~Hypertension~~
Due to: Arteriosclerotic heart disease — 5 Yrs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James M'C. Fenney M. D.
Address Union Memorial Hop. Date signed 6-23-47

X

G52863

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 157E

G52863 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Appamattox
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John L. Cates Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Male | 5. Color or race: White | 6 (a) Single, ~~married, widowed, or divorced~~: /

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-18-24

8. AGE: Years 22 | Months 9 | Days 6 | If less than one day ___ hr. ___ min.

9. Birthplace D.C. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name John Cates

13. Birthplace N.C.

MOTHER 14. Maiden Name Caroline Babcock

15. Birthplace Va.

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/27/47 (month) (day) (year)

(c) Cemetery ~~Crematory~~ Babcock

Location Appomattox, Va.

18 (a) Funeral director John A. Mitchell & Sons, Inc.

(b) Address 1900 Eutaw Place

19 (a) JUN 25 1947 Huntington Williams M.D.
(Date received by registrar) (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-24-1947 at 6:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-15-47 to 6-24-1947. and that I last saw him alive on 6-24 1947.

Immediate cause of death	Duration
Cardiac Failure	
Due to Pericarditis and Pleural hemorrhage	
Due to Tetralogy of Fallot. Surgery. Heart Disease	
Other Conditions Old Left Hemiplegia	

(Include pregnancy within 3 months of death)

Date of operation 6/19/47

Major findings of operation: Pulmonic Stenosis

of autopsy: Pericarditis, Tetralogy of Fallot

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas N.P. Johns

Address Johns Hopkins Hosp. Date signed 6/27/47

X

G52864 NH

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 54a

Registered No. G52864

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 year

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore - Edgemere
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2610 Bethlehem Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Samuel Lee Amos Jr.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17, 1931

8. AGE: Years	Months	Days	If less than one day
16	1	6	hr. min.

9. Birthplace Virginia (Town, county and state)
10. Usual Occupation School Boy
11. Industry or business

FATHER
12. Name Samuel Lee Amos Sr.
13. Birthplace Virginia

MOTHER
14. Maiden Name Annie Irene Asher
15. Birthplace Maryland

16 (a) Informant Records at Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 26/47 (month) (day) (year)
(c) Cemetery or crematory Ebenezer Methodist Cem. Glen Mar
Location Glen Mar

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St

19 (a) JUN 25 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1947, at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 22 1947 to June 23 1947 and that I last saw h im alive on June 23 1947

Immediate cause of death	Duration
Ependymoma of floor of fourth ventricle of brain	6 mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation June 23, 1947
Major findings of operation: Above
of autopsy: Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice M. Lacy, M.D. M. D.
Address Baltimore City Hospitals Date signed 6-29-47

G52865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 87c

G52865 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Please write age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Battery Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1211 Battery Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William J. McCarron Sr.

3 (b) If veteran, name war ✓

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Lyda A McCarron

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5th 1883

8. AGE: Years 64 | Months 1 | Days 19 | If less than one day: hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Capt. B+O RR

FATHER
12. Name James McCarron
13. Birthplace Ireland

MOTHER
14. Maiden Name Unknown
15. Birthplace Ireland

16 (a) Informant Mr. William J. McCarron
(b) Address 1211 Battery Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/27/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location 2930 Frederick Ave

18 (a) Funeral director John J. Cannon & Son
(b) Address 901-03 Hollins St.

19 (a) 6/25 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24th 1947, at 5.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/12/46 19 to 6/24/ 1947, and that I last saw him alive on 6/24/ 1947.

Immediate cause of death: Paralysis agitans — Duration: 2 y

Due to: —

Due to:

Other Conditions: none

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Weinberg M.D.
Address 1226 Hanover St. Date signed 6/25/ 1947.

G52866

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G52866

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 614 W. Fairmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) F
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 614 W. Fairmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME William A. Gross

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Mak | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Della

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 23. 1876

8. AGE: Years: 70 | Months: 11 | Days: — | If less than one day: hr. min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business:

FATHER
12. Name: John W. Gross
13. Birthplace: Balto Md

MOTHER
14. Maiden Name: Charlotte ?
15. Birthplace: Balto Md

16 (a) Informant: Irene Connish
(b) Address: 614 W Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-27-1947 (month) (day) (year)
(c) Cemetery or crematory: Mt. Auburn
Location:

18 (a) Funeral director: Mrs Hattie R. Williams
(b) Address: 322 N. Schroeder St.

19 JUN 25 1947 (b) (Registrar) Registrar

Printing for Williams, Mrs

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1947 at 8:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1947 to June 23 1947.
and that I last saw deceased alive on June 23 19 47

Immediate cause of death: Carcinoma of Stomach — Duration

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Keogler M. D.
Address 601 N Carrollton Ave Date signed 6/24/47

X

G52867

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (92)

G52867 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 527 Vincent St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) — 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 527 N. Vincent St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Clifton Taylor Herstal

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 1895.

8. AGE: Years	Months	Days	If less than one day
52	5		hr. min.

9. Birthplace Norfolk Va. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Beatrice Young
(b) Address 1637 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-26-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Kate R Williams
(b) Address 322 N Schroeder St.

JUN 25 1947 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1947, at 4:32 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 12 1947 to June 23 1947, and that I last saw h.IM alive on June 1947

Immediate cause of death: Congestive Heart Failure — Duration

Due to: Valvular Heart Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Douglas Sheppard M. D.
Address 604 N Bueltmore Date signed 6-25-47

X

652868 BC# G-80907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G52868 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital, Balt., Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore 22 Gwendolyn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7016 Hobbard Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME BABY GIRL KOPAS

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/18/47

8. AGE: Years	Months	Days	If less than one day
—	—	4	hr. — min.

9. Birthplace Baltimore Maryland (Town, county and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Julius Kopas
13. Birthplace Ohio

MOTHER
14. Maiden Name Dorothy Kean
15. Birthplace Virginia

16 (a) Informant James McCan M.D.
(b) Address Mercy Hospital, Balt. Md.

17 (a) Burial (b) Date thereof 6-25-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore

18 (a) Funeral director George A. Farley
(b) Address Gwynn Oak & Fayette St.

19 (a) JUN 25 1947 (Date received by registrar) (b) Huntington Williams, M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/22 1947 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/22 1947 to 6/22 1947 and that I last saw he alive on 6/22 1947.

Immediate cause of death Prematurity
Cardiac Failure

Due to Prematurity

Due to Atelectasis or Cardiac Failure

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operations: —

of autopsy —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James McCan M.D.
Address Mercy Hospital, Balt. Date signed 6/22/47

X

G52869

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163 H

G52869 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4026- Hayward Avenue.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4026- Hayward Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ARTHUR CHRISTIAN SPIEKERMAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	081-01-2239

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Helen M. Spiekerman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1903

8. AGE: Years	Months	Days	If less than one day
43	6	5	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Collector
11. Industry or business Regal Shop

FATHER
12. Name August Christian Spiekerman
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name S. Emma Maddux
15. Birthplace Salisbury, Md.

16 (a) Informant Mrs. Helen M. Spiekerman
(b) Address 4026 Hayward Ave.

17 (a) Burial (b) Date thereof 6/27/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

(b) Huntington Williams, M.D.
Registrar

6/25 1947
(Date received by registrar)

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24, 1947, at 12.15 P.M.

21. I certify that I took charge of the remains described above, held an insp. & inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Illuminating Gas.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-24-47 about 12 p. M. 4026- Hayward St.
(b) Where did injury occur? Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Gas stove, & burners open, from unlit

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 6-24-47

X

G52870

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G52870 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4504 Weitzel Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4504 Weitzel Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Viola Levy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Sol

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 30-1883

8. AGE: Years	Months	Days	If less than one day
63 64	7	26	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Thomas Thompson
13. Birthplace Balto Md

MOTHER 14. Maiden Name Mary McCann
15. Birthplace Balto Md

16 (a) Informant Morris, Rosenberg
(b) Address 700 N. Broad St Phila Pa

17 (a) Burial (b) Date thereof 6-27-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Sinai Cem
Location Phila, Pa

18 (a) Funeral director Jack Lewis Inc
(b) Address 1417 E. Baltimore St

19 (a) Filed by registrar (b) Registrar

JUN 26 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1947, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 25 1947, to June 25 1947, and that I last saw h[illegible] alive on June 25 1947.

Immediate cause of death	Duration
Congestive Heart Failure	2 days
Due to Cardio-Vascular Hypertensive disease	10 yrs.
Due to Arteriosclerosis	10 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Michael J. Dausch M. D.
Address 1 W. Overlea Ave Date signed 6-25-47

G52871

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G52871 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1460 Patapsco St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1460 Patapsco St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FLORENCE V. ECKHARDT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Wm. H. ECKHARDT

6 (c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) April 26, 1868

8. AGE: Years	Months	Days	If less than one day
79	1	28	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER 12. Name Richard JORDON

13. Birthplace Md.

MOTHER 14. Maiden Name Margaret Ann Thompson

15. Birthplace Md.

16 (a) Informant William H. ECKHARDT-(Husband)

(b) Address 1460 Patapsco St., Balto. 39 Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 27 1947 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet Cem.

Location Balto., Md.

18 (a) Funeral director A. Howard Evans

(b) Address 1405 Charles St. Balto 30, Md.

JUN 25 1947 (Date rec'd by registrar) (b) Farrington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24, 1947, at 11:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 3 1947, to June 24 1947, and that I last saw him alive on 6/24/47 1947.

Immediate cause of death	Duration
Hypertension & Cardio-Vasc Disease	
Due to	
Due to Cerebral Hemorrhage	12 Hrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Vincent M Fresaino M. D.

Address 1703 S. Charles St. Date signed 6/25/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52872 — BALTIMORE CITY HEALTH DEPARTMENT — G52872

CERTIFICATE OF DEATH 46

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 39 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 312 E. Hamburg St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carrie L. ~~Lamborn~~ (LeDuce) McCausland

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-12-1423

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Edw. L. McCausland
6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) June 23, 1901

8. AGE Years	Months	Days	If less than one day
46	—	1	....hr. ....min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation General Laborer for
11. Industry or business Tumbler Chemical Co.

FATHER
12. Name Wm. F. Vogel
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Helen E. Stocker
15. Birthplace Balto., Md. (Deceased)

16 (a) Informant Mrs. Helen C. Johnson
(b) Address 312 E. Hamburg St., Balto. 30, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 28, 1947 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Cem.
Location Q. R. Q. Co., Md.

18 (a) Funeral director J. Howard Evans
(b) Address 1400 S. Charles St. Balto 30, Md.

19 (a) 6-25-1947 (Date filed by registrar) (b) Huntington Willis Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-24 1947 at 4:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-17 1947 to 6-24 1947, and that I last saw h[illegible] alive on 6-24 1947.

Immediate cause of death	Duration
Overwhelming Bacteremia	7 days
Due to Liver & Kidney Abscesses	14 days
Due to Pylonephritis & Cystitis	3 weeks
Other Conditions Carcinoma of Rectum	

(Include pregnancy within 3 months of death)

Date of operation 5-27-47 & 6-10-47

Major findings of operation: Carcinoma of Rectum & Hemangiophelioma

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John C. Marman M. D.
Address Univ. Hosp. Date signed 6/24/47

G52873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V83a

G52873

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1415 Race St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 73
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1415 Race St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cord T. POOLE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary E. Poole (Nee Frank) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1871

8. AGE: Years 75 | Months 11 | Days 23 | If less than one day ..... hr. ..... min.

9. Birthplace Worcester Co., Md.
(Town, county, and state)

10. Usual Occupation Retired Firebrick Worker

11. Industry or business Gas & Elec. Co.

FATHER — 12. Name ? ?

FATHER — 13. Birthplace Md.

MOTHER — 14. Maiden Name ? ?

MOTHER — 15. Birthplace Md.

16 (a) Informant Clarence H. Poole (Son)

(b) Address 1415 Race St. Balto. 30, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 27 1947 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Balto. Co., Md.

18 (a) Funeral director G. Edward Evans

(b) Address 1400 S. Charles St. Balto. 30, Md.

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

JUN 25 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24, 1947 at 1:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1947 to Jun 24 1947, and that I last saw h alive on Jun 24 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 hrs.
Due to arteriosclerosis	Indef.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None.

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. E. Campbell M.D.

Address 164 Harvard St. Date signed June 25 1947

G52874

Maurice Carter G52874

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X937

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St. & Linden Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore ~~Co.~~ Stoneleigh
(If outside city or town limits, write RURAL and give town)
(d) Street No. 903 Wellington Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Maurice Carter

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-05-0516

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Lydia Carter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24-1876

8. AGE: Years 70 | Months 11 | Days — | If less than one day hr. min.

9. Birthplace Baltimore Co. Maryland
(Town, county, and state)

10. Usual Occupation Retired 7 years

11. Industry or business Car Repairman Bal. R.R.

FATHER 12. Name Uriah Carter

13. Birthplace Maryland

MOTHER 14. Maiden Name Rebecca Bayne

15. Birthplace Maryland

16 (a) Informant Maurice E. Carter

(b) Address 903 Wellington Road Stoneleigh

17 (a) Burial (b) Date thereof June 26-1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Providence
Location Baltimore Co. Maryland

18 (a) Funeral director Durgee Funeral Home

(b) Address 3931 Falls Road

(Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 June 1947 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947 to 24 June 1947 and that I last saw him alive on 24 June 1947.

	Duration
Immediate cause of death: Cardiac failure	3 days
Due to: Arterio-sclerotic cardio vascular disease	15 years
Due to:	
Other Conditions: Pneumonia, acute (Include pregnancy within 3 months of death)	
Date of operation:	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Andrew A. Rice

Address Md Gen. Hosp. Date signed 24 June

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G52875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

G52875 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1309 W. 40th St.
(c) Hospital or institution:
13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1309 W. 40th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Norman L. Trimble.

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-5308

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: F. Agnes Trimble

6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) March 10, 1913

8. AGE: Years	Months	Days	If less than one day
34	3	13	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Tool Maker.

11. Industry or business Ball machine Co.

FATHER
12. Name Howard H. Trimble.
13. Birthplace Md.

MOTHER
14. Maiden Name Zula E. Long.
15. Birthplace Md.

16 (a) Informant F. Agnes Trimble.
(b) Address 1309 W. 40th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 26 1947 (month) (day) (year)
(c) Cemetery or crematory Grace Lahnuch Memorial
Location Lakemont Ridge.

18 (a) Funeral director Kenneth F. Donaldson
(b) Address 2416-18 Lakemont Ave.

June 25 1947 (a) (b) Huntingtown, Md.
(Date received by registrar) Registrar

VS-156

To be approved by Medical Examiner

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1947, at 9:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 23, 1947, to June 23, 1947, and that I last saw h alive on 19

Immediate cause of death: Carcinoma of Lung

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward L. Parsons

Address 2037 Falls Rd. Date signed June 26 1947 M. D.

Thomas J. Williams, M.D.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52876

BALTIMORE CITY HEALTH DEPARTMENT ✓ G52876 Registered No.

CERTIFICATE OF DEATH 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1912 N. Fulton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1912 N. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amelia Steinz

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 28, 1866

8. AGE: Years	Months	Days	If less than one day
81	4	26	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Frederick Steinz
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Karcher
15. Birthplace Baltimore Md

16 (a) Informant Annie F. Lotz
(b) Address 1917 N. Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 26 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director Mr. & Mrs. John W. Teufel & Son
(b) Address 5311 Edmondson Ave

19 (a) (Date rec'd by registrar) JUN 25 1947 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1947, at 11:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 14 1947 to June 23 1947, and that I last saw h[illegible] alive on June 21 1947.

Immediate cause of death: Cardio-Renal Disease Chronic — Duration: 2 Weeks
Due to
Due to
Other Conditions Paralysis — 12 years
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation —
of autopsy: No

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury
23. Signature S. Lloyd Coleman M. D.
Address Catonsville Md. Date signed 6/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cost age is especially important. Physicians: please write the causes of death clearly and legibly.

G52877

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93

G52877 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1026 S Clinton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1026 S. Clinton St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fronie Arczyk (Arczyszewska)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Joseph Arczyk
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Cyzwinski
13. Birthplace Poland

MOTHER
14. Maiden Name unknown
15 Birthplace

16 (a) Informant Bertha Ratajczak
(b) Address 1026 S Clinton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/26/47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cemetery
Location Germans Hill Rd

18 (a) Funeral director John J. Duda
(b) Address 2869 Hudson St.

19 (a) Date received (registrar) JUN 25 1947 (b) Registrar Huntington Hillman

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1947, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1947 to June 22 1947 and that I last saw h[illegible] alive on June 21 1947

Immediate cause of death Hypertension and Cardio Vascular Disease

Due to Cerebral Hemorrhage

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

Duration
4 yrs
Nov [illegible]
6-22-47

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Ostermunk M. D.
Address 842 S Ext Ave Date signed 6-24-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY. WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52878

BALTIMORE CITY HEALTH DEPARTMENT ✓ G52878 Registered No.

CERTIFICATE OF DEATH 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits write RURAL and give town)
(d) Street No. 1170 Washington Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James A. Wilson Jr

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 1 - 1853

8. AGE: Years 93yrs | Months 10 | Days 23 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation —
11. Industry or business

FATHER
12. Name James A. Wilson
13. Birthplace Balto Md

MOTHER
14. Maiden Name Rebecca —
15. Birthplace Md

16 (a) Informant Mrs. Kidwell
(b) Address 2014 Griffis Ave

17 (a) Burial (b) Date thereof June 27 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Balto Md

18 (a) Funeral director Edward Toulson
(b) Address 2359 Washington Blvd

19 (a) JUN 25 1947 (b) Huntington Md
(Registrar's signature) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1947, at 6.30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 12 1947, to June 24 1947, and that I last saw h~~im~~er alive on June 24 1947.

	Duration
Immediate cause of death: Cerebral Arterio Sclerosis	10 yrs
Due to: Chr Myocarditis	10 yrs
Due to: Old Hemiplegia	2 yrs
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Milton L. Solomon M. D.
Address 29 S. Broadway Date signed 6/24/47

D 52879

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

30E

D. Registered No. 52879

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: Univ.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 511 W. Lafayette St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Ollie Proctor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Wm.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 12 1892

8. AGE: Years 55 | Months 5 | Days 5 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Wm. Johnson
13. Birthplace Va.

MOTHER
14. Maiden Name Maggie Stout
15. Birthplace Va.

16 (a) Informant William R. Proctor
(b) Address 653 N. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-29/1947 (month) (day) (year)
(c) Cemetery or crematory Laurel Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. George A. Hollard
(b) Address 1631 Division St. Hill Ave. Washington Boulevard, Md.

19 (a) JUN 30 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-22 1947, at 2 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-14 1947, to 6-22 1947, and that I last saw h[illegible] alive on 6-22 1947.

Immediate cause of death	Duration
Pulmonary embolism	
Due to	
Marasmus [illegible]	
Due to	
Cellulitis [illegible]	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. B. Hurley, M. D.
Address Date signed

VS 150

X

ARCo. 5-11 2500

B 53440 ✓ B 53440

HEALTH DEPARTMENT—CITY OF BALTIMORE

83a

CERTIFICATE OF DEATH

Registered No.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1423 Myrtle Ave St., ... Ward)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U.S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME John A Dorsey 14-2 Social security # 16-12-2965

(a) Residence: No. 1423 Myrtle Ave St., 14 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Helen R.

6. DATE OF BIRTH (month, day, year) Aug. 9, 1904

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42	10	13	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Bethlehem Steel

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore, Md.

FATHER

13. NAME C. Marcellus Dorsey

14. BIRTHPLACE (city or town) (State or country) Balto. Md.

MOTHER

15. MAIDEN NAME Mary A. Ireland

16. BIRTHPLACE (city or town) (State or country) Ellicott City Md.

17. INFORMANT Mrs. Helen R. Dorsey

(Address) 1423 Myrtle Ave.

18. BURIAL, CREMATION, OR REMOVAL

Place New Cathedral Date June 27 19 47

19. UNDERTAKER Jas. Leonard & Sons

(Address) 1615 Pennsylvania Ave

20. FILED JUN 26 1947 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) June 22, 1947

22. I HEREBY CERTIFY, That I attended deceased from June 1, 1947, to June 22, 1947

I last saw h. alive on June 21, 1947 death is said to have occurred on the date stated above, at ... m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	June 1947

Other contributory causes of importance: Hypertension

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ..... 19.....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? ..... If so, specify .....

(Signed) H. Stewart M. D.

(Address) 2302 Druid Park Drive

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D. 52681

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

✓ D 52881 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Fremont
(c) Hospital or institution: University Hosp. 4-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 323 N. Fremont
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Shellington, Ella

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife James

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1904

8. AGE: Years 42 | Months 8 | Days 14 | If less than one day hr. min.

9. Birthplace Wash. D. C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Morris Steat

13. Birthplace Anne Arundel

MOTHER 14. Maiden Name Sadie Wyatt

15. Birthplace Onancock, Va.

16 (a) Informant Mrs. Lottie Steat

(b) Address 255 Schroeder St.

17 (a) Burial (b) Date thereof 6-28-1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director Mrs. Geo. H. Hyde

(b) Address 1630 Pennsylvania Ave

19 (a) JUN 26 19[illegible] Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/24/ 1947, at 2:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/22 1947, to 6/24 1947, and that I last saw her alive on 6/24 1947

Immediate cause of death	Duration
Respiratory failure.	
Due to Cerebral Hemorrhage	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C.W. Lipston

Address Univ. Hosp. Date signed M. 6/25 D.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52882 (Certificate No.)

BALTIMORE CITY HEALTH DEPARTMENT ✓

CERTIFICATE OF DEATH 47D

Registered No. G52882

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green & Lombard
(c) Hospital or institution: University Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) Inv
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1555 Clifton ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME M. John Sloan

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-6754

4. Sex F (M)

5. Color or race W

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4th 1886

8. AGE: Years 61 | Months 2 | Days 24 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Shipping Clerk

11. Industry or business Arbus Bros.

FATHER
12. Name John L. Sloan
13. Birthplace Md

MOTHER
14. Maiden Name Ellen Johnson
15. Birthplace

16 (a) Informant Annie R. Foble
(b) Address 1555 Clifton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/28/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto., Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St. Baltimore, Md.

19 (a) JUN 26 1947 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-25 1947, at 9:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-25 1947 to 6-25 1947, and that I last saw h~~er~~ alive on 6-25 1947.

	Duration
Immediate cause of death Bronchogenic Carcinoma of lung -	
Pulmonary Congestion -	
Due to and Pneumonia -	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy 6-25-47

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hy Massenburg M.D.
Address Hilltop Date signed 6-25

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52883

BALTIMORE CITY HEALTH DEPARTMENT G52883

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 Rogers Ave
(c) Hospital or institution:
Aged Home of M.E. Church 27
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 15
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 Rogers Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leila A. Myers

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Albert S

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1, 1873

8. AGE: Years 73 | Months 8 | Days 3322 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William T Andrews
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Francis Hollingshead
15. Birthplace Baltimore Md

16 (a) Informant Marion Bates
(b) Address 2211 Rogers Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/28/47 (month) (day) (year)

(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Wilson & Son
(b) Address 2117 Eutaw St

19 (a) JUN 26 1947 (Date rec'd by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1947, at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 1947 to 6-23 1947 and that I last saw h. alive on June 23 1947.

Immediate cause of death: Coronary Thrombosis — Duration: 6 hours.
Due to: Arteriosclerosis — 20 yrs.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur J Davies M. D.
Address 1033 Park St Date signed 6-24-47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 G52884 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400-1404 W. Lexington St.
(c) Hospital or institution: Aged Women's & Aged Men's Homes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
or city or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Turner

3 (b) If veteran, name war: N
3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) September 18, 1857

8. AGE: Years: 89 | Months: 9 | Days: 7 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name James Turner
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary A. Warfield
15. Birthplace Maryland

16 (a) Informant Katherine E. Allen
(b) Address 1400 W. Lexington St.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 6/27/47 (month) (day) (year)
(c) Cemetery Warfield Family
Location Millersville Md

18 (a) Funeral director William Cook Inc.
(b) Address 1247 St. Paul St. Huntington Williams M.F.

19 (a) JUN 26 1947 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1947 at 6:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947 to June 25 1947, and that I last saw h S R alive on June 23 1947.

	Duration
Immediate cause of death Cardio-Resp Arrest Failure	
Due to Chronic Hypertension with Auricular Fibrillation	
Due to Acute heart block Bronchopneumonia	
Other Conditions Arteriosclerotic vascular disease	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Newland Edward Day M. D.
Address 4-E-33rd St -18 Date signed June 25 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G52885 Registered No.

83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400-1404 W. Lexington
(c) Hospital or institution: Aged Women's & Aged Men's Homes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 yrs. 8 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie T. Carnes

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: 6160

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) June 10, 1858

8. AGE: Years: 89 | Months: - | Days: 14 15 | If less than one day: hr. min.

9. Birthplace Baltimore - Maryland (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER — 12. Name George H. Trainor
13. Birthplace Maryland

MOTHER — 14. Maiden Name Sara Greenwood
15. Birthplace Maryland

16 (a) Informant Katherine Allen
(b) Address 1400 W. Lexington st.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 6/27/47 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Balto.
Location " Md.

18 (a) Funeral director William Booth Jones
(b) Address 1217 St. Paul Street

19 (a) JUN 26 1947 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1947, at 9 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1947, to June 25 1947. and that I last saw her alive on June 23 1947.

	Duration
Immediate cause of death Respiratory failure	
Due to Cerebral hemorrhage —	
Due to Hypertension Arteriosclerotic vascular disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howland Edward Day M. D.
Address 4-E-33 USPHS - 15 Date signed June 25 1947

G52886

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G52886 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 420 Dunkirk Ave. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME George T. Ford

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married, widowed, or~~ divorced.
Male	White	Divorced

6 (b) Name of ~~husband or~~ wife Dorothy T. Ford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1885

8. AGE: Years	Months	Days	If less than one day
61	9		....hr. ....min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Attendant
11. Industry or business Walters Art Gallery

FATHER
12. Name George T. Ford
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Carrie Mitchell
15. Birthplace Balto. Md.

16 (a) Informant A. S. Polk
(b) Address 420 Dunkirk Rd

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 6/28/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 E. Pratt St.

19 (a) JUN 26 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1947, at 7:15 PM

21. I certify that I took charge of the remains described above, held an ~~Inquest~~ Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Howard A. Woolsey M.D. Medical Examiner.
Date signed 6-26-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52887

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G52887 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1130 Ridgely Street
(c) Hospital or institution: Home 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1130 Ridgely Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard L. Ward

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	220-05-7335

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ethel B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1903

8. AGE: Years	Months	Days	If less than one day
44	0	24	hr. min.

9. Birthplace Tuscaloosa, Alabama (Town, county, and state)
10. Usual Occupation Erector
11. Industry or business Bethlem Steel, Key Highway

FATHER
12. Name Carsner Ward
13. Birthplace Alabama

MOTHER
14. Maiden Name Cordelia Clemens
15. Birthplace Alabama

16 (a) Informant Mrs. Ethel Ward
(b) Address 1130 Ridgely Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 28, 47 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Meadow Ridge

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) JUN 26 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1947 at 6:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 14 1947 to June 25 1947 and that I last saw him alive on June 25 1947

Immediate cause of death	Duration
Pulmonary Tuberculosis	
Interstitial advanced.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Johnson P. Unlock, Jr.
Address 122 N. Wash. Blvd. Date signed 6/27/47 M D

Unlock

D. Thomas Thorton
2878 Harford Rd.

G52888

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12/10 G52888 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1406 Cooksie Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1406 Cooksie Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James E. Hemling

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Widowed

6 (b) Name of husband or wife Johanna Hemling
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 12, 1860

8. AGE: Years	Months	Days	If less than one day
87	5	12	hr. min.

9. Birthplace Talbot County, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Hemling
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Brigid Dacy
15. Birthplace Ireland

16 (a) Informant Mary Walker
(b) Address 1406 Cooksie Street

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 6/27/47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Anne Arundel County, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) JUN 20 (Date rec'd by registrar) (b) Huntington Williams, M. D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24, 1947, at 7:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 22 1947, to June 24 1947, and that I last saw h[illegible] alive on June 23 1947.

Immediate cause of death

	Duration
(a) Coronary Occlusion	3 hrs
Due to Arterio Sclerosis & Hypertension	3 yrs
Due to Mitral Regurgitation	20 yrs
Due to Chronic Interstitial Nephritis	2 yrs

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. F. A. Storms, M. D.
Address 2878 Harford Rd Date signed 6-25-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52889

BALTIMORE CITY HEALTH DEPARTMENT G52889
CERTIFICATE OF DEATH 1947 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1515 Montpelier St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1515 Montpelier St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Butz Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Mollie Watermeyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10, 1862

8. AGE: Years	Months	Days	If less than one day
85	3	13	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace " "

MOTHER
14. Maiden Name " "
15. Birthplace " "

16 (a) Informant Mrs. Milford Cunzeman
(b) Address 1515 Montpelier St.

17 (a) Burial (b) Date thereof 6/26/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1934 Broadway

19 (a) JUN 26 1947 (b) Carrington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1947, at 5 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 1947, to present 19, and that I last saw h[illegible] alive on June 21 1947.

Immediate cause of death	Duration
Arterio-sclerotic cardiac vascular heart	3 years
Due to Angina.	
Due to Senility	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Theodore L. Hagamen M. D.
Address 2802 Harford Rd Date signed 6/25/47

VS 150

G52890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G52890 Registered No. 43a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3902 Fait Ave.
(c) Hospital or institution:
26-9
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3902 Fait Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Viola E. Wolbert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Anton T. Wolbert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1902

8. AGE: Years	Months	Days	If less than one day
44	6	28	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Lebon
13. Birthplace Baltimore

MOTHER
14. Maiden Name Fannie Smith
15. Birthplace Baltimore

16 (a) Informant Anton T. Wolbert
(b) Address 3902 Fait Ave

17 (a) Burial (b) Date thereof 6/28/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 R[illegible] Huntington Williamsport, Md.

19 (a) JUN 26 1947 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1947, at 5:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 21 1947 to June 24 1947 and that I last saw her alive on June 24 1947

Immediate cause of death	Duration
Cerebral Hemorrhage	3 days
Due to Cerebral Vascular Sclerosis	
Due to	
Other Conditions Was a severe epileptic.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. B. Stevens M. D.
Address 3402 Eastern Ave Date signed 6/29/47

Water 6/4
G52891 6/15/47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G52891 V157E

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes 26-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 900 Hewitt Way (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHERYL LYNN WATSON (Baby)

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1944

8. AGE: Years	Months	Days	If less than one day
2	6	5 4	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Ronald E. Watson
13. Birthplace Princess Ann Md.

MOTHER
14. Maiden Name Lucy Bloodsworth
15. Birthplace Mt. Vernon, Md.

16 (a) Informant Mr. Ronald E. Watson
(b) Address 900 Hewitt Way

17 (a) Burial (b) Date thereof 6/27/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Episcopal Cem.
Location Princess Ann, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Ave. Balto., Md.

19 (a) (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1947 at 9:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1947 to June 24 1947 and that I last saw h.. alive on June 24 1947.

Immediate cause of death	Duration
Lymphatic Leukemia.	
Due to Congenital Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Conrad Gordon M. D.
Address 2201 W. North Ave. Date signed 6-24-47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G52899 Registered No. 50

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 530 E. 30th Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-4
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 530 E. 30th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELISE KEES GROVE

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	214-03-7419

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	divorced

6 (b) Name of husband or wife Edgar Grove
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1889

8. AGE: Years	Months	Days	If less than one day
57	11	11	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation forelady
11. Industry or business Kramer Co.

FATHER
12. Name John Zimmerman
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Louisa
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. August Grove
(b) Address 603 E. 30th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/27/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

V S 190

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25, 1947 at 6:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from AUG. 1946 to 25 JUNE 1947 and that I last saw her alive on 25 JUNE 1947

Immediate cause of death	Duration
Cachexia	3 MOS
Due to Carcinoma of breast (Right)	2 YRS
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lloyd E. Taylor M. D.
Address 3902 Greenmount Ave Date signed 25 June 1947

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54 B

X G52893 File No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town Maryknoll (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rev. Robert F. Morse

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1919

8. AGE: Years	Months	Days	If less than one day
28	2	23	hr. min.

9. Birthplace Kiss. (Town, county, and state)
10. Usual Occupation Clergyman
11. Industry or business

FATHER
12. Name Frederick A. Morse
13. Birthplace Kiss.

MOTHER
14. Maiden Name Mildred Anderson
15. Birthplace Kiss.

16 (a) Informant Rev. John F. Comber
(b) Address Maryknoll N.Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/28/47 (month) (day) (year)
(c) Cemetery or crematory Maryknoll
Location Maryknoll N.Y.

18 (a) Funeral director Martin Kelly & Sons
(b) Address 1827 N. North Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1947, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 23 1947 to June 25 1947, and that I last saw alive on June 25 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Cerebellar tumor left hemisphere	
Due to (Malignant)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation June 23 1947
Major findings of operation: Cerebellar tumor, left hemisphere
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John C. Orzechowski M. D.
Address St. Agnes Hospital Date signed June 25 1947

X

G52894

BALTIMORE CITY HEALTH DEPARTMENT G52894

CERTIFICATE OF DEATH 44B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 42 days
(e) Length of stay in Baltimore (yrs., mos., or days) 42 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla. (b) County
(c) City or town Palm Beach (If outside city or town limits, write RURAL and give town)
(d) Street No. 200 Barton ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Rubel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Julia H. Ryan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-29-83

8. AGE: Years 64 | Months 1 | Days 26 | If less than one day hr. min.

9. Birthplace: Austria (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER 12. Name: Carl Rubel

13. Birthplace: Germany

MOTHER 14. Maiden Name: Johanna Springer

15. Birthplace: Germany

16 (a) Informant: Records

(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 6/28/47 (month) (day) (year)

(c) [redacted] crematory: Loudon Park.

Location: Chicago, Ill.

18 (a) Funeral director: John O. Mitchell Sons

(b) Address: 1900 Eutaw Place,

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

45

20. DATE OF DEATH June 25 1947 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 13 1947 to June 25 1947 and that I last saw h[illegible] alive on June 25 19 47.

Immediate cause of death: Hodgkin's Disease — Duration: 7yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: A M Knight M. D.
Address: Johns Hopkins Hosp. Date signed

X

G52895

BALTIMORE CITY HEALTH DEPARTMENT G52895 Registered No.

CERTIFICATE OF DEATH 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 837 Park Ave
(c) Hospital or institution: 11

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 837 Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Aldah Fryffe

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24/1875

8. AGE: Years 71 | Months 6 | Days 1 | If less than one day ..... hr. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation retired
11. Industry or business "

FATHER
12. Name Thos. Fryffe
13. Birthplace Md

MOTHER
14. Maiden Name Mary Fryffe
15. Birthplace Md

16 (a) Informant Beulah H. Fryffe
(b) Address 837 Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 27/47 (month) (day) (year)
(c) Cemetery or crematory Monocacy Cemy.
Location Beallsville Md

18 (a) Funeral director John O. Whitehill & Son
(b) Address 1900 Eutaw Place

19 (a) JUN 26 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1947, at 7 00 M

21. I certify that I took charge of the remains described above, held an Aut. Ed Chesp thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature William G. Kelbrick M.D.
Medical Examiner.
Date signed June 25-1947

G52896

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √94a

G52896 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Warrington Apts.
(c) Hospital or institution: none 12-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Warrington Apts. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Elisabeth M. Burnett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife Paul M. Burnett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1873

8. AGE: Years	Months	Days	If less than one day
74	2	23	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name George Jackson
13. Birthplace Md.

MOTHER
14. Maiden Name Elisabeth Markland
15. Birthplace Baltimore, Md.

16 (a) Informant Eleanor B. Clifford
(b) Address Doublet Hill Road, Westron, Mass.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 6/26/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John A. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) JUN 26 1947 (Date filed by registrar) Thomas Worthington Williams, M. D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 24, 1947 to June 24, 1947 and that I last saw her alive on June 24, 1947

Immediate cause of death	Duration
Coronary Thrombosis	1 days
Due to Coronary Arteriosclerosis	?
Due to Chronic Hypertension	Years ?
Other Conditions Chronic Arthritis + Osteoporosis (Include pregnancy within 3 months of death)	Years ?

Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence ~ at ~ M
(c) Where did injury occur? ~ (City or town) ~ (County) ~ (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ~ (Specify type of place) While at work? ~
(e) Means of injury ~

23. Signature Frank M. Ogden, M. D.
Address 2701 N. Calvert St. Date signed June 25, 47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~C52897~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C52897 83a — Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 508 Brune St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 508 Brune St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13, 1879

8. AGE: Years	Months	Days	If less than one day
68	5	11	hr. min.

9. Birthplace Winnsboro S. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Gilet Lewis
13. Birthplace South Carolina

MOTHER
14. Maiden Name Hannah
15. Birthplace South Carolina

16 (a) Informant Maggie Feaster
(b) Address 303 N. Pine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 24 1947 (month) (day) (year)
(c) Cemetery or crematory Chester
Location South Carolina

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 (a) JUN 26 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1947, at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1947 to June 24 1947, and that I last saw h[illegible] alive on June 24 1947

Immediate cause of death: Cerebral Embolism — Duration 14 hrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address [illegible] Date signed 6/26/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52898

BALTIMORE CITY HEALTH DEPARTMENT G52898 Registered No.

CERTIFICATE OF DEATH 1937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Frederick Square Hospital 18

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 2
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1048 W. Saratoga St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arabella Parker

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/2/92

8. AGE: Years 54 | Months 7 | Days 20 | If less than one day hr. min.

9. Birthplace New Jersey (Town, county, and state)

10. Usual Occupation Colored wife

11. Industry or business —

FATHER 12. Name Edmund Boggs

13. Birthplace ?

MOTHER 14. Maiden Name Mary Jones

15. Birthplace ?

16 (a) Informant: C. Burgo

(b) Address 518 S. 15th St. Phila. Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-26-47 (month) (day) (year)

(c) Cemetery or crematory Arbutus

Location

18 (a) Funeral director Adolphus Halstead

(b) Address 918 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1947, at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 21 1947, to June 22 1947, and that I last saw her alive on June 22 1947

Immediate cause of death: Cerebral hemorrhage, right — Duration 1 day

Due to

Due to

Other Conditions: Hypertensive Cardio-Vascular Disease — ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stanley B. Klyanovicz M.D.

Address Franklin Square Hosp. Date signed 6-27-47

82a

G52899

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G52899 / 50 — Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 104. W. University Parkway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ind (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 104 W. University Parkway.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Carrie M. Fricht

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Ernest J. Fricht
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 5-1863

8. AGE: Years	Months	Days	If less than one day
84	3	19	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Home duties
11. Industry or business

FATHER
12. Name Jacob Thuere
13. Birthplace Germany

MOTHER
14. Maiden Name Rosine B. Fisher
15. Birthplace Germany

16 (a) Informant Mrs. Rosine E. Bullock
(b) Address 550 University Parkway

17 (a) Burial (b) Date thereof June 27/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore Md.

18 (a) Funeral director Maurice E. Syfer
(b) Address 1600 N. Kenwood Ave.

19 (a) JUN 20 1947 (Baltimore, Md.)
(Registered by Registrar) (Date) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1947 at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1947 to June 24 1947 and that I last saw h.r alive on June 24 1947.

Immediate cause of death	Duration
Carcinoma of lungs about	5 mo.
Due to carcinoma of right breast (Primary)	1 year
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank Bullock M. D.
Address 2220 Garrison Blvd Date signed 6-26/47

X

1 G52900 Duplicate

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G52900

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Rayner
(c) Hospital or institution: West Baltimore Gen'l Hosp 16-T
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1413 Longwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Hagg

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/2/1848

8. AGE: Years 48 | Months 8 | Days 21 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation House Duties

11. Industry or business

FATHER 12. Name John Imhoff
13. Birthplace Germany.

MOTHER 14. Maiden Name Helen Pfeifle
15. Birthplace Germany.

16 (a) Informant Andrew H. Haag
(b) Address 1413 Longwood ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 28-1947 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge Cem
Location Baltimore Md

18 (a) Funeral director Maurice E. Syfer
(b) Address 1600 W. North Ave

19 (a) 26 1947 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/24 1947 at 11:02 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/15 1947 to 6/24 1947 and that I last saw her alive on 6/24 1947.

Immediate cause of death	Duration
Pulmonary Edema	
Due to Cerebral Hemmorhage	
Due to Hyperkinsive C-V Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamen Friedenwald M. D.
Address WCS+ Baltimore Gen'l Date signed 6/25/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 426

G52901 No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1900 N. CAROLINE ST.
(c) Hospital or institution: ST Josephs Hospital 27-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 59 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3509 W. Belvedere Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Zula B. Fidler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/22/87

8. AGE: Years	Months	Days	If less than one day
59	6	2	hr. min.

9. Birthplace Baltimore (Town, county or state)
10. Usual Occupation Housekeeper
11. Industry or business Private family

FATHER 12. Name Geo Albert Goodwin
13. Birthplace Alexandria Va

MOTHER 14. Maiden Name Matilda E. Dellis
15. Birthplace Prince William Co Va

16 (a) Informant Mrs Margaret E. Black
(b) Address 3509 W. Belvedere Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/26/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Loring Byers
(b) Address 5005 Reisterstown Rd

19 (a) June 26 1947 (Signature and title) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/24/1947 at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/10 1947 to 6/24 1947, and that I last saw he alive on 6/24 1947.

Immediate cause of death	Duration
Cardiac Failure	
Due to Hypertensive cardiovascular disease	
Due to	
Other Conditions Healed perforated round duodenal ulcer	

(Include pregnancy within 3 months of death)

Date of operation 6/14/47
Major findings of operation: Cholelithiasis cholecystitis
of autopsy Cardiac failure

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M. D.
Address 1. Scott Hayes Date signed 6/27/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-107482 G52902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH G52902

Registered No. 136

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 16-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1142 N. Stricker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Harries -or- Walter Harried

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Separated

6 (b) Name of husband or wife Mary or Nancy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15- 1896

8. AGE: Years	Months	Days	If less than one day
51	2	7	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Longshoreman
11. Industry or business

FATHER
12. Name William Harries -or- Norman Harried
13. Birthplace Md.

MOTHER
14. Maiden Name Esabelle -or- Isobel
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 6-26-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Balto. Md.

18 (a) Funeral director Geo. V. Kelson
(b) Address 1303 Presstman St.

19 (a) JUN 26 1947 (b) Function for Williams M.D.
(Date received by registrar) (Registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22- 1947, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-10- 1947 to 6-22- 1947, and that I last saw him alive on 6-22- 1947

Immediate cause of death	Duration
RESPIRATORY FAILURE	
Due to FAR ADVANCED BILATERAL PULMONARY TUBERCULOSIS	1 YEAR
Due to	
Other Conditions NONE	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry J. Hoeska M.D.
Address Balto. City Hosp. Date signed 6/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH G52903

Registered No. 3698

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2121 Ettings St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2121 Ettings St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Idele Buttler

3 (b) If veteran, name war

3 (c) Social Security Account No. 246-44-0914

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Martin Buttler
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years 45 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation House work

11. Industry or business own home

FATHER
12. Name Louis Lee Sr
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Maggie Boyer
15. Birthplace Calvert Co.

16 (a) Informant Mr Audrey Rambo
(b) Address 2121 Ettings St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/25/47 (month) (day) (year)
(c) Cemetery or crematory Mt Zion
Location Md

18 (a) Funeral director Geo. B. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-24- 1947 at 3:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-1 1947 to 6-24 1947.
and that I last saw her alive on 6-23 1947.

Immediate cause of death	Duration
Gastric Carcinoma	6 mo
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank A Saunders M. D.
Address 1029 N. Stricker St Date signed 6-24-47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52904
11-111567

BALTIMORE CITY HEALTH DEPARTMENT 121
CERTIFICATE OF DEATH Registered No. G52904

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 815 N. Bruce St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Cliford Colvin

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1933

8. AGE: Years	Months	Days	If less than one day
13	10	26	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation School
11. Industry or business

FATHER
12. Name Robert Colvin
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Hicks
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 6/27/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Preston ave

19 (a) (Date rec'd by registrar) (b) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24, 1947, at 2PM M

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1947 to June 24 1947, and that I last saw h im alive on June 24 1947

Immediate cause of death	Duration
Appendiceal Abscess	
Due to Gangrenous Appendicitis	6 days
Due to	
Other Conditions Pelvic Abscess, Toxemia (Include pregnancy within 3 months of death)	

Date of operation June 20, 1947
Major findings of operation: Append. Abscess & Gangrenous Appendicitis
of autopsy: Absent.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice M. Lacy, M.D. M. D.
Address Baltimore City Hosp Date signed 6-25-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G52905 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 72 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt. (If outside city or town limits, write RURAL and give town)
(d) Street No. 514 Park Ave Balt (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Barham Feig

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife: None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-24-75

8. AGE: Years	Months	Days	If less than one day
72	5	1	hr. min.

9. Birthplace Balt. Md. (Town, county, and state)
10. Usual Occupation Retired school principal
11. Industry or business

FATHER
12. Name Andre Joseph Feig
13. Birthplace Balt. Md

MOTHER
14. Maiden Name Rebecca Buchwalter
15. Birthplace Balt. Md.

16 (a) Informant Mrs A D Emmart
(b) Address 3551 Newland Rd Balt

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/28/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meads and Son
(b) Address 805 N. Calvert Street

19 (a) JUN 26 1947 (b) Registered by registrar Washington Williams Registrar
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1947, at 9:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1947 to June 25 1947 and that I last saw h. alive on June 25 1947.

Immediate cause of death	Duration
Pulmonary Infarction	15 mins
Due to Arteriosclerotic heart dis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. D.
Address Date signed

Hospital X 6-25-47

G52906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G52906 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland + Rayner Sts.
(c) Hospital or institution: West Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
Street No. 1708 Ramsay ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William T. HARRISON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of ~~husband~~ or wife Pete Jimmy Z (Edmonds)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 8, 1874

8. AGE: Years	Months	Days	If less than one day
72	8	18	hr. min.

9. Birthplace Rock Hall Md (Town, county, and state)
10. Usual Occupation Carpet cleaner
11. Industry or business

FATHER 12. Name James Harrison
13. Birthplace Md

MOTHER 14. Maiden Name Martha Jones
15. Birthplace Md

16 (a) Informant Mrs E Harrison
(b) Address 1708 Ramsay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 28 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3201 Frederick Rd.

18 (a) Funeral director Henry H Withers Jr
(b) Address 4101 Edmondson Ave

19 (a) JUN 26 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-26 1947, at 7 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-19 1947 to 6-26 1947, and that I last saw him alive on 6-26 1947.

Immediate cause of death	Duration
Pulmonary Edema	
Due to Arteriosclerotic Heart Disease	
Due to Carcinoma of Stomach	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin F Jackson M.D.
Address WBGH Date signed 6/26

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G52907 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2552 W. Fayette St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2552 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Ungar
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Eva
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15-1869

8. AGE: Years	Months	Days	If less than one day
77	9	9	hr. min.

9. Birthplace Hungary (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name — Ungar
13. Birthplace Hungary

MOTHER
14. Maiden Name Rothmann
15. Birthplace Hungary

16 (a) Informant Mrs. Eva Ungar
(b) Address 2552 W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 27/1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3501 Frederick Ave

18 (a) Funeral director Harry H. Wittle
(b) Address 410 Edmondson Ave

19 (a) JUN 26 1947 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 4th 1947 to June 24th 1947, and that I last saw h[illegible] alive on June 24th 1947.

Immediate cause of death Cardiac Failure — Duration 4 hrs

Due to Myocarditis — 1 year

Due to Senility — [illegible]

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Q. Poulton
Address 3904 Benson Blvd Date signed 6/25/47

G52908

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

G52908 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 122 S. Conkling
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 122 S. Conkling St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Staub

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Marie (nee Thoma)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26 1855

8. AGE: Years 71 Months 9 Days 28 If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John Staub
13. Birthplace Germany

MOTHER
14. Maiden Name Justine Schafer
15. Birthplace Germany

16 (a) Informant Adolf Staub
(b) Address Mayer Keidel Rd. Govans

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/27/27 (month) (day) (year)
(c) Cemetery or crematory Trinity
Location E. Donnell St.

18 (a) Funeral director Edward Connelly
(b) Address 415 Eastern Ave. Bmd.

19 (a) JUN 26 1927 Filed by registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1927, at 3 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1927 to June 24 1927, and that I last saw h[illegible] alive on June 23 1927.

Immediate cause of death	Duration
Acute Cardiac Dilatation	2 days
Due to Chr. Valvular Heart Disease	34 yrs.
Due to	
Other Conditions Arteio. Sclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address 1511 E 33rd St. Date signed 6/28/27

G52909 G52909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 104B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Light Street
(c) Hospital or institution: So. Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore Zone 20
(c) City or town R.F.D. 14 Box 160
(If outside city or town limits, write RURAL and give town)
(d) Street No. Edmondson Md.
(If rural give location)
(e) Citizen of foreign country? None (Yes or No)
If yes, name country

3 (a) FULL NAME Herman M. Finkelstein

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-0543

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	S.

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 5, 1908

8. AGE: Years	Months	Days	If less than one day
39	5	17	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Cleaners - Dyers.

11. Industry or business

FATHER
12. Name Abraham Finkelstein
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah Pearlowitz
15. Birthplace Russia

16 (a) Informant Meyer Finkelstein
(b) Address 2969 Oakley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 27/47 (month) (day) (year)
(c) Cemetery or crematory Beth Jacob Cem
Location Rosedale

18 (a) Funeral director Sol Levinson Bros
(b) Address 1124-26 W North Ave

[redacted]26 1947 (Date rec'd by registrar) Registration No. Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25, 1947 at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 25 1947 to June 25 1947 and that I last saw H. M alive on June 25 1947.

Immediate cause of death: Acute Coronary Failure — Duration: 5 min

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation June 25, 1947
Major findings of operation: Sub Mucous Resection
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ross L. Lyman M. D.
Address So. Balto. Gen. Hosp. Date signed

VS 150

G52910

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH

G52910
Registered No.

157a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: Univ.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Martinsburg
(If outside city or town limits write RURAL and give town)
(d) Street No. R.F.D. #2
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George K. Snyder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/1945

8. AGE: Years	Months	Days	If less than one day
1	7		hr. min.

9. Birthplace W. Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Kenneth Snyder
13. Birthplace W. Va

MOTHER
14. Maiden Name Margaret Iren Jacobs
15. Birthplace W. Va

16 (a) Informant Mrs. W. Snyder
(b) Address Martinsburg W. Va

17 (a) Burial (b) Date thereof 6-28-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Spring Mills
Location Hedgesville W. Va

18 (a) Funeral director J. E. Hagenbuch Son
(b) Address Elkridge Md

19 (a) JUN 26 1947 (b) Huntington-Williamsport
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 June 1947, at 7:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 24 June 1947 to 25 June 1947 and that I last saw him alive on 25 June 1947.

Immediate cause of death	Duration
MENINGITIS - TYPE NOT AS YET DETERMINED	
Due to	
Due to	
Other Conditions CONG. HYDROCEPHALUS	

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation: None
Basilar
of autopsy: Hydrocephalus meningitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. E. Bauw M. D.
Address University Hospital Date signed 26 Jun 47

VS 150

81a

G52911 BOH
S-81854

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

G52911
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave 16
(c) Hospital or institution: West Balto Gen Hosp 15-13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3507 Virginia Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roy Allen Distiller

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: infant
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 6/22/47
8. AGE: Years | Months | Days: 3 | If less than one day: hr. min.
9. Birthplace Balto Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Melvin Distiller
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Florence Fox
15. Birthplace Balto Md

16 (a) Informant Melvin Distiller
(b) Address 3507 Virginia Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-26-47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel
Location
18 (a) Funeral director Jack Lewis Inc
(b) Address 1429 Balto St
19 (a) (b) Registrar

JUN 26 1947
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1947 at 1 40 A. M
21. I certify that death occurred on the date above stated; that I attended deceased from 6-22 1947 to 6-25 1947 and that I last saw h alive on 19

Immediate cause of death: Adrenal Hemorrhage & congested lungs — Duration
Due to
Due to
Other Conditions Prematurity
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy adrenal hemorrhage & congested lungs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature E. D. Treptow M. D.
Address W. Balto Gen Hosp Date signed 6-26

G52912 | BALTIMORE CITY HEALTH DEPARTMENT | G52912 Registered No.

CERTIFICATE OF DEATH 61

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1137 N. Milton Ave
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Eva Schmidt

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Edward C. Schmidt
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 26 1887

8. AGE: Years 60 | Months 0 | Days 28 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore - Md.
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business.....

FATHER
12. Name John Moore
13. Birthplace Baltimore - Md.

MOTHER
14. Maiden Name Annie Harriman
15. Birthplace Baltimore - Md.

16 (a) Informant Edward Schmidt
(b) Address 36 Admiral Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/28/47 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location North Ave.

18 (a) Funeral director John C. Miller Inc.
(b) Address 2435 E. Eleven St

19 (a)..... (b)..... (Date filed by registrar) Registrar

JUN 26 1947

OS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/24/47 1947, at 6:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/23/47 1947 to 6/24/47 1947, and that I last saw her alive on 6/24 1947.

Immediate cause of death Pneumonia Fulminans ..... | Duration .....

Due to Cerebral Hemorrhage .....

Due to HCVD & ASCVD. .....

Other Conditions Diabetes Mellitus .....

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature Leon Rosenbaum M. D.
Address Sinai Hosp. Date signed 6/24/47

Rosenbaum 93D

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52913 / 517538

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131B

G52913 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1002 Shellbank Road. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edna Johnson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Charles.
6 (c) If alive, give age 39. years

7. Birth date of deceased (mo., day, yr.) 10-15-06

8. AGE: Years 40 | Months 6 | Days 10 | If less than one day ..... hr. ..... min.

9. Birthplace S. C. (Town, county, and state)

10. Usual Occupation Home-wife

11. Industry or business

FATHER
12. Name Alonzo Madison
13. Birthplace S. C.

MOTHER
14. Maiden Name Inez Castelow
15. Birthplace S. C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 29 47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location Balto. County Md

18 (a) Funeral director Mrs. P. H. Elliott Jr.
(b) Address 1129 N. Carlton

19 (a) ..... (b) ..... (Date received by registrar) Registrar

JUN 26 1947
VS 150
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1947 at 1155 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 1947 to June 25 1947, and that I last saw her alive on June 25 1947

Immediate cause of death Uremia — Duration 1 mo

Due to Pyelonephritis, Chronic

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis Harvey Harris M. D.
Address Johns Hopkins Hosp. Date signed June 26 1947

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

G52914 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1719 N. Forest Park Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1719 N. Forest Park Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Irma Louise Heacock

3 (b) If veteran, name war --
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or ~~wife~~ Walter I. Heacock
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1920

8. AGE: Years	Months	Days	If less than one day
26	8	21	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation House-wife
11. Industry or business

FATHER
12. Name Henry G. Ermer
13. Birthplace Baltimore Co., Md.

MOTHER
14. Maiden Name Lizzetta C. Muth
15. Birthplace Baltimore Co., Md.

16 (a) Informant Mr. Walter I. Heacock
(b) Address 1719 N. Forest Park Ave.,

17 (a) Burial (b) Date thereof 6-27-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Md.

18 (a) Funeral director J. Howard Stoong
(b) Address 3207 W. North Ave.,

26 1947 (b)
(Signature of Registrar) Registrar

VS 150 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24, 1947, at 9.22 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1947 to June 24 1947 and that I last saw him alive on June 24 1947.

Immediate cause of death	Duration
Pneumonia	
Due to Carcinoma of Oesophagus	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Exploratory
Major findings of operation: Carcinoma of Oesophagus
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. C. Summers M. D.
Address 4500 Dolfield Ave Date signed June 26

Dr. Golley
G52915

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46 B

Registered No. G52915

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2201 Southern Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2201 Southern Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Springer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widoed

6 (b) Name of husband or wife Samuel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 8, 1866

8. AGE: Years	Months	Days	If less than one day
80	10	19	hr. min.

9. Birthplace Europe
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name ? Kerekes
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Anna Nagy
(b) Address 2201 Southern Ave.

17 (a) Burial (b) Date thereof 6/30/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Grand View Cem.
Location Johnstown, Pa.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) (Date received by registrar) Huntington Williams Registrar

JUN 26 1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26th, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to 6/26 1947 and that I last saw her alive on 6/26 1947

Immediate cause of death Carcinoma of Stomach — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury KYLE W. GOLLEY

23. Signature Kyle W. Golley M. D.
Address 5705 Harford Rd. Date signed 6/27/47

X

G52916 BALTIMORE CITY HEALTH DEPARTMENT G52916
CERTIFICATE OF DEATH 157E Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Texas (b) County
(c) City or town Lufkin (If outside city or town limits, write RURAL and give town)
(d) Street No. 131 Alton Pl. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Stephanie Strand

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-15-43

8. AGE: Years	Months	Days	If less than one day
3	7	11	hr. min.

9. Birthplace Texas (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER 12. Name Jack L. Strand
13. Birthplace Texas

MOTHER 14. Maiden Name Joy Marie Collins
15. Birthplace Texas

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof June 26-47 (month) (day) (year)
(c) Cemetery or crematory LUFKIN
Location TEXAS
18 (a) Funeral director John O. Mitchell & Son
(b) Address 1900 Eutaw Pl.
19 (a) (Date rec'd by registrar) (b) Registrar

JUN 25 50 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 1947 at 10 25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 25 1947 to June 1947 and that I last saw h[illegible] alive on June 26 1947.

Immediate cause of death: Attempted Anastomosis of Pulmonary & Subclavian Arteries — Duration:
Due to: Tetralogy of Fallot — 3yrs
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation 6/25/47
Major findings of operation: SAME
of autopsy: SAME

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard C. Clay, M.D.
Address John Hopkins Hosp. Date signed 6/26/47

X

G52917

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G52917
Registered No.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3001 Milford
(c) Hospital or institution:
78
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3001 Milford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph R. Streckfus.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Frances M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15-1913

8. AGE: Years 34 | Months 3 1 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation [illegible]

11. Industry or business

FATHER
12. Name George C.
13. Birthplace Baltimore

MOTHER
14. Maiden Name Frances A. Reidy
15. Birthplace Baltimore Md.

16 (a) Informant Mrs Frances A. Streckfus
(b) Address 3001 Milford Ave.

17 (a) Burial (b) Date thereof 6-28-1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Cross.
Location Cath. Co. Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1406 Light St.

19 (a) Date received by registrar JUN 26 1947 (b) Registrar Washington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1947 at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1947 to June 25 1947 and that I last saw h[illegible] alive on June 25 19 47

Immediate cause of death	Duration
Acute Coronary Thrombosis	12hrs
Due to Coronary Sclerosis	Unknown
Due to	
Other Conditions Migraine	years

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Mendeler M. D.
Address 651 N Bentalou Date signed 6/26/47

X

G52918

BALTIMORE CITY HEALTH DEPARTMENT ✓ G52918 Registered No.

CERTIFICATE OF DEATH 45F

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 601 N. East Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 601 N. East Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES CONRAD BERL

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mary C. (nee O'Neill)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19, 1883

8. AGE: Years	Months	Days	If less than one day
64	1	5	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business American Smelting Refinery

FATHER
12. Name John Peter Berl
13. Birthplace Germany

MOTHER
14. Maiden Name Louisa Deems
15. Birthplace Baltimore, Md.

16 (a) Informant Mary C. Berl - wife
(b) Address 601 N. East Avenue

17 (a) Burial (b) Date thereof 6/27/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) (b) Registrar
(Delivered by registrar)

JUN 26 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1947 at 12:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 47 to June 24 19 47 and that I last saw him alive on 6-24 19 47

Immediate cause of death Carcinoma, Lungs + Throat — Duration 1 Mo.
Due to
Due to
Other Conditions Hypertension Diabetes Sinusitis — Duration 2½ yr
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James F. Kaguraft M.D.
Address 3614 W. Belvedere Date signed 6-25-47

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52919
CWK-111640

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G52919
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 422 S. Regester Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hugh Dolan

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16-1879

8. AGE: Years	Months	Days	If less than one day
68	-	9	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-27-47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location Balto. County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 (a) (Date signed by registrar) (b) Huntington Williams, M.D.

JUN 26 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 19 47 at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 23 19 47 to June 25 19 47 and that I last saw h. im alive on June 25 19 47.

Immediate cause of death	Duration
Respiratory Failure.	
Due to Pulmonary tuberculosis,	yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Pulm. Tbc.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herman Beetham M. D.
Address B.C.H. Date signed 6/26/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

Registered No. G52920

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2012 Fountain St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME J. Martin Konigsmark

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 216-03-0195
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of ~~husband or~~ wife Agnes
6 (c) If alive, give age 51 years
7. Birth date of deceased (mo., day, yr.) 10-5 1895
8. AGE: Years 51 Months 8 Days If less than one day hr. min.
9. Birthplace New Berlin Germany
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace UNKNOWN

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace UNKNOWN

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-28 47 (month) (day) (year)
(c) Cemetery or crematory BALTIMORE NATIONAL
Location MARYLAND

18 (a) Funeral director George A Weber
(b) Address 705 S. Linn st

19 (Date received by registrar) JUN 27 1947 Huntington Williams M.D.

MEDICAL CERTIFICATION A

20. DATE OF DEATH June - 26 1947, at 3.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from June-26 1947, to June-26 1947, and that I last saw him alive on June-26 1947.

Immediate cause of death: Pulmonary Edema — Duration: 2 hrs
Due to: Arteriosclerotic, hypertensive cardiovascular disease, and — Duration: unknown
Due to: Rheumatic heart disease with mitral stenosis — Duration: "
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E. Mason M. D.
Address Johns Hopkins Hosp. Date signed 26 June 47

VS 150

G52921

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G52921

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) One
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 306 N. Eutaw St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Frank McNeil

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years	Months	Days	If less than one day
39			.....hr. .....min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Unknown
11. Industry or business

FATHER
12. Name.....
13. Birthplace

MOTHER
14. Maiden Name.....
15. Birthplace

16 (a) Informant.....
(b) Address

17 (a).....(b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location. University Medical School JUN 23 1947
Commissioner of Health
18 (a) Funeral director.....
(b) Address.....
19 JUN 27 1947 Huntington Williams, M.D.
(Date rec'd by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1947, at 2.05 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage (spontaneous)
Due to.....
Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Earl L. Kagan M.D.
Medical Examiner.
Date signed 5-27-47

G52922

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G52922
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 Greenmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY TREEHEARN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 66 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Unknown
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) ..... (b) Date thereof .....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JUN 23 1947

18 (a) Funeral director Commissioner of Health
(b) Address

JUN 27 1947 Washington Williams MD
(Date rec'd by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 1947, at 8 45 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Intracranial hemorrhage,
Arteriosclerosis, history of
~~Due to~~ High blood pressure

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George B. Merrill M.D.
Medical Examiner.
Date signed 6/17/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C52923 L - 111337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH .13B

Registered No. C52923

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 3
(d) Street No. 317 W. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Richardson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12, 1871

8. AGE: Years 76 | Months - | Days 12 | If less than one day ..... hr. ..... min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER
12. Name Joe Richardson
13. Birthplace Pa.

MOTHER
14. Maiden Name Sarah Bradley
15. Birthplace Pa.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/28/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Isaac L Brown & Son
(b) Address 1617 W Montgomery St

19 (a) JUN 27 1947 (Date rec'd by registrar) (b) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1947, at 8pm M

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1947, to June24 1947, and that I last saw h imalive on June 24 1947.

Immediate cause of death	Duration
Pulmonary Tuberculosis Far advanced	2 years
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Wright M. D.
Address Balto. City Hospitals Date signed 6-24-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52924

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G52924

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2731 Eastern Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2731 Eastern Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Samuel E Stallings

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Margaret E Stallings
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation
11. Industry or business Watchman

FATHER
12. Name Dont Know
13. Birthplace Balto

MOTHER
14. Maiden Name Dont Know
15. Birthplace Balto

16 (a) Informant Edw W Fuller
(b) Address 1210 Harwood Road

17 (a) Entombment (b) Date thereof June 28
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2108 Orleans St

19 (a) JUN 27 1947 Huntington Williams M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1947, at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to June 25 1947, and that I last saw h live, alive on 6-25 1947.

Immediate cause of death	Duration
Cardio-vascular disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene Zellers, M.D.
M. D.
Address 2739 Eastern Ave Date signed 6/25/47.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

G52925 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 74 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6311 Glen Spring Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Vieweg.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: George Vieweg

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1872

8. AGE: Years 74 | Months 5 | Days 28 | If less than one day hr. min.

9. Birthplace Maryland. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Christian Mueseh.
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Deppenschlag
15. Birthplace Maryland

16 (a) Informant Mrs H. L. Finch
(b) Address 6301 Bellona Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 28 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Nelson

19 (a) JUN 27 1947 (Date rec'd by registrar) Huntingtow Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/26/47 19 , at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/24 1947 to 6/26 1947, and that I last saw h[illegible] alive on 6/25 1947.

Immediate cause of death Cyanosis
asphyxiation & Exhaustion — Duration

Due to Ca. of esophagus with metastases

Due to Pneumonia.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph J. Katonis M.D.
Address Church Home & Hosp. Date signed 6/26/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G52926

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Charles (Greenway) 34th Sts.
(c) Hospital or institution:
home - Apt.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) abt. 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Charles & 34th Sts.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No

3 (a) FULL NAME Robert Lucas Chamberlaine

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Louise H. Chamberlaine
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) Sept. 27 or 28 1860

8. AGE: Years 86 | Months 8 | Days 28-29 | If less than one day ..... hr. ..... min.

9. Birthplace Norfolk - Va.
(Town, county, and state)

10. Usual Occupation Retired - Pres.

11. Industry or business Knickerbocker Choc. Co.

FATHER
12. Name Richard Henry Chamberlaine
13. Birthplace Norfolk - Va.

MOTHER
14. Maiden Name Maria Elizabeth Lovey
15. Birthplace Baltimore - Va.

16 (a) Informant Mr. Chas. F. L. Chamberlaine - (Son)
(b) Address 100 Harrison St. - Clarksburg - W. Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-28-47 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. - Md.

18 (a) Funeral director Stewart & Mowen Co.
(b) Address 108 W. North Ave. - Balto. - 1

19 JUN 27 1947 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 1947, at 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 23 1947, to June 26 1947, and that I last saw him alive on June 25 1947.

Immediate cause of death	Duration
Cerebral Vascular Accident	3 days
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frances W Gluck M. D.
Address 715 Park Ave Date signed 6/27/47

VS 150

X

G52927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G52927

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 506 Brune st.
(c) Hospital or institution:
17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 506 Brune St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Garrett (Darby)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	C.	Single.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/2/1874

8. AGE: Years	Months	Days	If less than one day
72	11	23	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Theadore Garrett
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Garrett
15. Birthplace ~~506 Brune Street.~~ Md

16 (a) Informant Annie Garrett
(b) Address 506 Brune St

17 (a) Burial (b) Date thereof 6 25 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory W. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 416 Penna ave

19 JUN 27 1947 Huntington for Williams, M.D.
(Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-25-1947 at 4:30 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Pulmonary Tuberculosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Rogers M.D.
Medical Examiner.
Date signed 1-26-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C52928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48B

Registered No. C52928

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 809 E. 33rd St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 809 E. 33rd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME REBECCA G. HILBERG

3 (b) If veteran, name war: -

3 (c) Social Security Account No.: -

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John L. Hilberg

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1882

8. AGE: Years 64 | Months 6 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James Gaffney
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Sidney L. Lee
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Daniel Ritter
(b) Address 809 E. 33rd St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/27/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) JUN 27 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24, 1947 at 6:30a M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 6 1947, to June 24 1947, and that I last saw h[illegible] alive on June 23 1947.

Immediate cause of death	Duration
Carcinoma uterus	1-Mos
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. D. Lapsley M. D.
Address 4215 Patterson Park Ave. Date signed 6/26/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52929

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 87c

Registered No. G52929

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1129 St. Paul St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Peter Joseph Kelly
3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Widower

6 (b) Name of husband or wife: Nellie Regina Kelly
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): March 18, 1880

8. AGE: Years	Months	Days	If less than one day
67	3	8	hr. min.

9. Birthplace: Brooklyn, N. Y. (Town, county, and state)
10. Usual Occupation: Retired Master Plumber
11. Industry or business

FATHER
12. Name: Bartholomew Kelly
13. Birthplace: Ireland

MOTHER
14. Maiden Name: -- Harding
15. Birthplace: Ireland

16 (a) Informant: Mrs. Donald Shipley
(b) Address: 1129 St. Paul Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/30/47 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral Cem.
Location: Baltimore, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) JUN 27 1947 (Date rec'd by registrar) Thurlington White Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 June 1947, at 1 30/ P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2 June 1947 to 26 June 1947 and that I last saw h.i.m. alive on 26 June 1947

Immediate cause of death: Parkinsonian Disease — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Joseph R Liberto M. D.
Address: Bon Secours Hosp. Date signed: 26 June 47

X

G52930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G52930 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 Park Heights Ave
(c) Hospital or institution: Mt Sinai Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3318 Gwynn Falls Pkway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Gertrude Cooper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Louis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Abel
13. Birthplace Russia

MOTHER
14. Maiden Name Kay
15. Birthplace Russia

16 (a) Informant Louis Cooper
(b) Address 3318 Gwynn Falls Pkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-27-47 (month) (day) (year)
(c) Cemetery or crematory Windsor Mill Pk
Location Windsor Mill Pk

18 (a) Funeral director Jenk Seymour
(b) Address 1439 E. Balto St

JUN 27 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-25-1947 at 6 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 11, 1947 to June 25, 1947 and that I last saw her alive on June 25, 47

Immediate cause of death: Cerebral hemorrhage and paralysis — Duration: 14 days

Due to: Advanced arterio-sclerosis and hypertension — about 10 yrs.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter L Dublin M. D.
Address 220 Garrison Blvd (Date signed) 6/26/47

G52931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓94a

Registered No. G52931

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. The information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 6 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1144 Cleveland St
(If rural give location)
(e) Citizen of foreign country? .....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Frances A Ellis

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Edward
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 4-12-81

8. AGE: Years	Months	Days	If less than one day
66	2	13	..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation House work at home
11. Industry or business .....

FATHER
12. Name Frank Ridgell
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Wisk
15. Birthplace Md.

16 (a) Informant .....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/28/47 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Ritchie Highway

18 (a) Funeral director John J Conway & Son
(b) Address 101-03 E Fallsway

19 JUN 27 1947 by Hutchinson Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-25-1947, at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-24 1947, to 6-25 1947, and that I last saw her alive on 6-25 1947

Immediate cause of death	Duration
Myocardial infarction (Enter only one cause per line for a, b, and c.)	39 hrs.
Due to Coronary thrombosis	39 hrs.
Due to Coronary arteria-sclerosis	Several years
Other Conditions Essential hypertension (Include pregnancy within 3 months of death)	

Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury.....

23. Signature Maxwell Williams M. D.
Address Johns Hopkins Hosp. Date signed 6-26-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52932

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G52932

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3827 BROOKLYN AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3827 BROOKLYN AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THURMAN MORRIS

3 (b) If veteran, name war —

3 (c) Social Security Account No. 705-07-9474

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife IRENE SCHAEFER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 3, 1888

8. AGE: Years 59 | Months 1 | Days 22 | If less than one day hr. min.

9. Birthplace BALTIMORE CO.
(Town, county, and state)

10. Usual Occupation

11. Industry or business RAILROAD

FATHER
12. Name NATHAN MORRIS
13. Birthplace BALTIMORE CO.

MOTHER
14. Maiden Name SARAH BILLINGSLEA
15. Birthplace BALTIMORE CO.

16 (a) Informant MRS. IRENE MORRIS
(b) Address 3827 BROOKLYN AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6 / 28 / 47 (month) (day) (year)
(c) Cemetery or crematory GLEN HAVEN
Location RITCHIE HIGHWAY

18 (a) Funeral director JOHN F. DENNY, INC
(b) Address 715 LIGHT ST.

19 (a) JUNE 27 1947 Huntington Williams, M.D. (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 25, 1947, 2:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1947 to June 25 1947 and that I last saw h alive on June 24 1947.

Immediate cause of death	Duration
(a) Embolism	5 minutes
Due to (b) Pulmonary Artery Thrombosis	
Due to (c) Left Femoral Vein	Today
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 102 W. Chase St. Date signed 6/27/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C52933

NH 11D364

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V13B

Registered No. C52933

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 102 N. Ellwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Schriver, Lillian

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife William B. Schriver
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2, 1904

8. AGE: Years	Months	Days	If less than one day
43	1	24	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Harry Barr
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Bennes
15. Birthplace Maryland

16 (a) Informant Records at Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof June 30-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem.
Location E Donnell St.
18 (a) Funeral director John A. Miller
(b) Address 2334 Jefferson St.
19 (Date rec'd by reg.) JUN 27 1947 Signature for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 1947, at 5:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 2 1947 to June 26 1947, and that I last saw her alive on June 26 1947.

Immediate cause of death Pulmonary T.B.c — Duration 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A S Harte M. D.
Address Balto. City Hosp. Date signed 6/26/47

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 652934

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland + Rayner
(c) Hospital or institution:
West Baltimore Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 140 S. Franklintown Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis W. ~~Romeser~~ Romaer

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M Romaer

6 (b) Name of husband or wife Margaret ~~Romeser~~

6 (c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Aper. 14, 1879

8. AGE: Years	Months	Days	If less than one day
68	2	11	... hr. ... min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Meat Dealer
11. Industry or business

FATHER
12. Name Edward M. Romaer
13. Birthplace Baltimore

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. J. R. Hilleary
(b) Address 2517 W. Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 28/47 (month) (day) (year)
(c) Cemetery or crematory Mount Olivet Cem.
Location

18 (a) Funeral director Charles J. Schwab
(b) Address 3512 Frederick Ave

19 (a) (Date received by registrar) Huntington Williams, M.D. Registrar

JUN 27 1947
150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-25 1947 at 7 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-23 1947 to 6-25 1947 and that I last saw h. l. m alive on 6-25 1947.

Immediate cause of death	Duration
Subarachnoid Hemmorrhage	
Due to Cerebral Arteriosclerosis	
Due to Generalized Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Liebman M. D.
Address WBGH Date signed 6/26/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52935 BC#D 56239 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH / 577 G52935 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 810 N. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Archie James Jones Jr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age 1942 years

7. Birth date of deceased (mo., day, yr.) 8-26-45 42

8. AGE: Years	Months	Days	If less than one day
4 2	9	29	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Archie Jones
13. Birthplace Va.

MOTHER
14. Maiden Name Virginia Morton
15. Birthplace Va.

16 (a) Informant Bond
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-28-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location A.A. Co., Maryland

18 (a) Funeral director Robert E. Williams
(b) Address 1515 McElderry st.

(a) Date received 6-27 1947 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1947, at 1030 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 24 1947, to June 25 1947, and that I last saw him alive on June 25 1947.

Immediate cause of death	Duration
Respiratory Failure	
Due to Intracranial neoplasm	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Barton Childs M. D.
Address Johns Hopkins Hosp. Date signed 6-28-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V47D

G52936
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1423 E. Madison St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1423 E. Madison St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaiah Pree

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-12-9218

4. Sex: M
5. Color or race: C
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Eva

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Sept 5 1887

8. AGE: Years 64 | Months 9 | Days 21 | If less than one day: hr. min.

9. Birthplace Bath md
(Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER 12. Name Jacob Pree
13. Birthplace Va

MOTHER 14. Maiden Name Ida Noles
15. Birthplace Va

16 (a) Informant Eva Pree
(b) Address 1423 E. Madison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 29 1947 (month) (day) (year)
(c) Cemetery or crematory Orbutys Memorial
Location Bath md

18 (a) Funeral director Robert E. Wallington
(b) Address 515 McElderry St

JUN 27 1947 (Date received by registrar) (b) Huntington Wallington M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 1947, at 1:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/14 1947 to 6-26 1947 and that I last saw him alive on 6-26 1947.

Immediate cause of death: Squamous cell carcinoma of lung — Duration: Sev. mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rayner Browne M.D.
Address 1500 E. Monument Date signed 6-27

Dr. Haywood Wilson 617 W. 40th St. Yes 1946

G52937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

G52937 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2251 W. Baltimore St
(c) Hospital or institution: Y
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2251 W. Balto. St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna C. Conner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband Jonathan Conner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 10th 1866

8. AGE: Years 80 | Months 7 | Days 16 | If less than one day hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Colwell
13. Birthplace Md.

MOTHER
14. Maiden Name Laura McGee
15. Birthplace Md.

16 (a) Informant Laura M. Schroeder
(b) Address Masonic Home, Eckeysville Md.

17 (a) Burial (b) Date thereof 6/28/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st.

19 JUN 27 1947 (b) Livingston Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26th 1947 at 3.15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 11 1947 to June 26 1947 and that I last saw h e alive on June 26 1947.

Immediate cause of death
Carcinoma Liver — Duration 6 mo
Due to Metastasis from Ryovary
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J H Wilson
Address 617 W. 40th St Date signed 6/27/47 M. D.

G52938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G52938

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1929 Brunt St
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 47yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1929 Brunt St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie T. Cooley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Levi Cooley

6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) Feb 3 - 1901

8. AGE: Years 46 | Months 4 | Days 22 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name [redacted]
13. Birthplace Calvert Co Md

MOTHER
14. Maiden Name Mary Banks
15. Birthplace Calvert Co Md

16 (a) Informant Margaret Curtis
(b) Address 2434 McCulloh St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 29-47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn
Funeral director Wm Stokes
(b) Address 1463 N. Carey St

19. (Date received by Registrar) June 27 1947 (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1947, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-1 1946, to 6-25 1947, and that I last saw her alive on 6-22 1947.

Immediate cause of death	Duration
Chr. card. ren. disease	
Hypertension	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H Edmund Levin
Address 3400 Hilton Rd Date signed 6-25-47

G52939

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1328

G52939 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3110 E. Monument Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3110 E. Monument St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS HENRY SCHUEBEL

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of ~~husband~~ or wife Antoinette (nee Pinkus)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1889

8. AGE: Years 57 | Months 9 | Days 5 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name Henry Schuebel
13. Birthplace unknown

MOTHER 14. Maiden Name Caroline Herwig
15. Birthplace unknown

16 (a) Informant Mrs. Antoinette Schuebel - wife
(b) Address 3110 E. Monument Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/28/47 (month) (day) (year)
(c) Cemetery or ~~cemetery~~ Oak Hill
Location Horner's Lane, Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (c) JUN 27 1947 (Date rec'd by registrar) (d) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/25 1947 at 3:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1947 to 6-25 1947, and that I last saw h~~im~~ alive on 6-24 1947.

Immediate cause of death: Chr Bronchiectasis — Duration 5-12-46
Antecedent cause Tuberculosis — 5-2-47
Due to: — c —
Due to:
Other Conditions None
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? None
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature E. A. Schimunek
Address 842 S. Exeter Date signed 6-27-47

VS 150

Birth Certificate

G52940 G-82736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 159

Registered No. G52940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & Saratoga Sts, City 2

(c) Hospital or institution: Mercy Hospital 27

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County — Baltimore

(c) City or town BALTIMORE Middle River (If outside city or town limits, write RURAL and give town)

(d) Street No. 16 HENDERSON ROAD VICTORY VILLA (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country —

3 (a) FULL NAME BABY GIRL DOLL

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 24 JUNE 1947

8. AGE: Years — Months — Days 1 If less than one day: 8 hr. 38 min.

9. Birthplace BALTIMORE, MARYLAND (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Warren Doll

13. Birthplace Baltimore, Maryland

MOTHER 14. Maiden Name Ida Warfield

15. Birthplace Anne Arundel County, Maryland

16 (a) Informant James Moler M.D.

(b) Address Mercy Hospital, Balt. Md

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6/27/47 (month) (day) (year)

(c) Cemetery or crematory PARKWOOD

Location CITY

18 (a) Funeral director WIEDEFELD & SON

(b) Address 6 FERNMOUNT & 2ND ST.

19 JUN 27 1947 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/24 1947 at 7:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/24 1947 to 6/24 1947 and that I last saw her alive on 6/24 1947.

Immediate cause of death Premature Baby — Duration

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature James Moler M. D.

Address Mercy Hospital, Balt. Date signed 6/24/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52941

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 132

Registered No. G52941

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Taneytown
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Elmer Jerome Rippeon

3 (b) If veteran, name war —
3 (c) Social Security Account No. 216-05-0682

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife ?
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) April 20, 1908

8. AGE: Years 39 | Months 2 | Days 7 | If less than one day hr. min.

9. Birthplace New Market, Md.
(Town, county, and state)
10. Usual Occupation Boatswain
11. Industry or business Seafarer

FATHER
12. Name John Rippeom
13. Birthplace New Market, Md.

MOTHER
14. Maiden Name Ida May Zimmerman
15. Birthplace New Market, Md.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (b) Date thereof 6 - 30 - 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Methodist Cemetery
Location Unionville, Maryland
18 (a) Funeral director C. O. Fuss & Son
(b) Address Taneytown, Md.
19 (a) JUN 27 1947 (Date rec'd by registrar) Carrington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1947, at 5:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1947, to June 27 1947, and that I last saw h in alive on June 27 1947

Immediate cause of death Nephritis, acute, hemorrhagic with uremia — Duration UNKNOWN

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 6/27/47

VS 150

X

G52942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

Registered No. G52942

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1184 Washington Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1184 Washington
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Karolina Kara

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John Kara

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1875

8. AGE: Years	Months	Days	If less than one day
72	3	4	hr. min.

9. Birthplace Csurtura - Hungary
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Joseph Zsuma
13. Birthplace Csurtura

MOTHER
14. Maiden Name Not known
15. Birthplace Csurtura

16 (a) Informant Walter Sabbe
(b) Address 1184 Washington Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-27-47 (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Baltimore Md

18 (a) Funeral director Wyatt & Brochstein
(b) Address 900 N. Charles St

19 [illegible] 27 1947 [illegible]

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1947, at 11:A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1947, to June 27 1947, and that I last saw her alive on June 24 1947.

Immediate cause of death	Duration
Cerebral Thrombosis	6 days
Due to Cerebral Arteriosclerosis	3 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John G. Urbanek, Jr.
Address 122 W. Preston St. Date signed 6/25/47 D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C52943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. C52943

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 917 S. Bayliss st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 917 S. Bayliss st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Edward Scott

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-03-5946

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	colored	married

6 (b) Name of husband or wife Mary J. Scott
6 (c) If divorced give age years

7. Birth date of deceased (mo., day, yr.) Mar-11-1875

8. AGE: Years	Months	Days	If less than one day
72 71	3	14	hr. min.

9. Birthplace New Kent County - Va.
(Town, county, and state)
10. Usual Occupation laborer
11. Industry or business

FATHER
12. Name Holley Scott
13. Birthplace New Kent County - Va

MOTHER
14. Maiden Name Nancy Scott
15. Birthplace New Kent County - Va

16 (a) Informant Mary J. Scott
(b) Address 917 S Bayliss st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jun-22-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.
18 (a) Funeral director Mrs Ida Bailey
(b) Address 1421 E. Jefferson st

JUN 27 1947 (b) Washington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June - 25 1947, at 6:36 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 47 to June 25 1947 and that I last saw h alive on June 24 1947

Immediate cause of death Embolism

Duration

Due to Tumor of lungs Lung Cancer

Due to

Other Conditions Dacom pensated Heart over

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. Trowbridge M. D.
Address 1613 E. N. Ave Date signed 6/27/47

VS 150

X 13

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 124B

Registered No. G52944

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1408 N Gay St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1408 N Gay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** LeRoy Delmont Elder

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	M.

6 (b) Name of husband or wife Mildred A Elder
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 27 1889

8. AGE: Years	Months	Days	If less than one day
58	4	29	hr. min.

9. Birthplace Locke Haven Pa (Town, county, and state)
10. Usual Occupation machine Operator
11. Industry or business Acrod Corp.

FATHER
12. Name Charles Elder
13. Birthplace Pa.

MOTHER
14. Maiden Name Natura Longwell
15. Birthplace Pa

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-28-47 (month) (day) (year)
(c) Cemetery or crematory Moreland
Location Balto.

18 (a) Funeral director C. J. Fanning & Son
(b) Address 1938 E. Lafayette Ave

19 (Date rec'd by registrar) JUN 27 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1947, at 7:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1947 to 6-25 1947, and that I last saw him alive on 6-25 1947

Immediate cause of death	Duration
Portal Cirrhosis	1 yr.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Dewey Moores M. D.
Address 3108 Belair Rd Date signed 6-26-47

VS 150

G52945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G52945 Registered No. 91a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert
(c) Hospital or institution: Union Mem. Hospital 9+ days
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1732 Homestead St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Henry Phillip Rappe

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-05-2895

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Ruby L. Rappe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 7, 1891

8. AGE: Years	Months	Days	If less than one day
55	8	18	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business

FATHER
12. Name Frederick Rappe
13. Birthplace Germany

MOTHER
14. Maiden Name Johanna Herrchen
15. Birthplace Germany

16 (a) Informant Frederick Rapp
(b) Address 1732 Homestead St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 28, 1947 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave.

18 (a) Funeral director Schenuth + Donovan
(b) Address 3614-16 Gertrude Ave.

JUN 27 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Address

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1947, 4:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 21 1947 to June 25 1947 and that I last saw h[illegible] alive on June 25 1947

Immediate cause of death	Duration
Subacute bacterial endocarditis	2 mos
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Negative

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Huntington Williams M. D.
Address Baltimore Md Date signed June 27 1947

Completed X

G52946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G52946

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 613 E. Baltimore St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME EARLE MOXLEY

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
47			....hr. ....min.

9. Birthplace Unknown
(Town, county, and state)
10. Usual Occupation.....
11. Industry or business.....

FATHER
12. Name.....
13. Birthplace.....

MOTHER
14. Maiden Name.....
15. Birthplace.....

16 (a) Informant.....
(b) Address.....

17 (a).....(b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location University Medical School JUN 23 1947

18 (a) Funeral director.....
(b) Address.....

(a) Date received by Registrar JUN 27 1947 (b) Commissioner of Health Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH June 7 1947, at 9 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH.....
Bronchopneumonia;
Myocardial degeneration
Dilatation of heart
Fat infiltration of liver
Subdural hemorrhage
Other Conditions Pulmonary emphysema

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature George E. Merrill M.D.
Medical Examiner.
Date signed 6/9/47

X

G52947

BC# D70645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓158

G52947 Registered No.

· MARGIN RESERVED FOR BINDING · PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balt. (If outside city or town limits, write RURAL and give town)
(d) Street No. 527 W Lexington (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert Perry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-9-47

8. AGE: Years	Months	Days	If less than one day
3 mo.			hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Queenie Penny
15. Birthplace S. Ca.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JUN 23 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUN 27 1947 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-18-47 19..., at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-22-47, to 6-14-47, and that I last saw h... alive on 6-18-47.

Immediate cause of death	Duration
Malnutrition	
Due to Feeding Problem.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Autopsy ePC

Major findings of operation: liver, spleen & lungs, malnutrition and hydrothorax

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charlotte Hawkins M.D. M. D.

Address University Hosp. Date signed 6-23-47

X

G52948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G52948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Ave
(c) Hospital or institution: Md. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 28 N. Kossuth St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Collier

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Newborn

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/20/47

8. AGE: Years — Months — Days — If less than one day — hr. 3 min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name William P Collier

13. Birthplace La.

MOTHER 14. Maiden Name Edith M.

15. Birthplace Balto. Md

16 (a) Informant William P. Collier

(b) Address 28 N. Kossuth St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School JUN 23 1947

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) JUN 27 1947 (Date rec'd by registrar) Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/20/47 19 ... at 2 W/A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/20 1947 to 6/20 1947, and that I last saw him alive on 6/20/47

Immediate cause of death Pneumothorax

Due to (Pregnancy 7½ mo. only)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas C. Jones, M.D.

Address Md Gen Hosp Date 6/20/47

VS 150

G52949 BC# D82426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registration No. G52949

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Lakedrive Near Wallpt. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Hyman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-18-47

8. AGE: Years	Months	Days	If less than one day
		6 5	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Sigmund Hyman
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary Bloom
15. Birthplace Mass

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Extension JUN 27 1947

18 (a) Funeral director
(b) Address Commissioner of Health
JUN 27 1947 (Signature of local registrar) Wallington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 18 1947 to June 23 1947 and that I last saw living on June 23 1947.

Immediate cause of death Prematurity

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Allan Chesley M. D.
Address Date signed

G52950

BALTIMORE CITY HEALTH DEPARTMENT

Bk# b82162 CERTIFICATE OF DEATH V160c

G52950 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave 16
(c) Hospital or institution: Mercy Balto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) newborn
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5606 Kenstertown Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Estep

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/25/47

8. AGE: Years | Months | Days | If less than one day: hr. 10 min.

9. Birthplace Balto Md — (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Robert E Estep

13. Birthplace Balto Md

MOTHER 14. Maiden Name Ruth Carroll

15. Birthplace Baltimore Md —

16 (a) Informant 5606 Kenstertown

(b) Address Baltimore Md

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location JUN 27 1947

18 (a) Funeral director Johns Hopkins Medical School

(b) Address Commissioner of Health

19 (c) (Date received by Registrar) JUN 27 1947 Hester Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1947, at 5.04 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-25 1947, to 6-25 1947 and that I last saw her alive on 6-25 1947.

Immediate cause of death	Duration
Asphyxia	
Due to Prolapse of Cord	
Due to	
Other Conditions Breech Presentation	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: Abnormal lungs congested

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. J. Treptow M. D.

Address W. Balto Gen Hosp Date signed 6-26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52951

BALTIMORE CITY HEALTH DEPARTMENT X 1318

CERTIFICATE OF DEATH

Registered No. G52951

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Richmond & Druid Pk
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Lisbon
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Andy Rhodes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years 43 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace W. Va.
(Town, county, and state)

10. Usual Occupation Farm Hand

11. Industry or business

FATHER 12. Name Albert Rhodes

13. Birthplace Kentucky

MOTHER 14. Maiden Name Angie Hill

15. Birthplace Kentucky

16 (a) Informant

(b) Address

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School JUN 27 1947

18 (a) Funeral director Commissioner of Health

(b) Address

(c) Date rec'd JUN 27 1947 by (Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1947 at 5-15 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 12 1947 to June 21 1947 and that I last saw him alive on June 21 1947.

Immediate cause of death Uraemia — Duration

Due to Chronic glomerulo-nephritis

Due to

Other Conditions Hypertension CVD due to (2)
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles R. Holman

Address Univ. Hosp. Date signed 6/26/47

X

C52952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. C52952

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3023- Eastern Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Wladyslaw) Walter Odachowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Stella

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) March 24, 1897

8. AGE: Years	Months	Days	If less than one day
50	3	2	....hr. ....min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Baker

11. Industry or business

FATHER
12. Name Michael Odachowski
13. Birthplace Poland

MOTHER
14. Maiden Name Catharine Juzbowicz
15. Birthplace Poland

16 (a) Informant Mrs. Stella Odachowski
(b) Address 3023 Eastern Avenue

17 (a) Burial (b) Date thereof 6/30/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M. F. Sadowski & Sons
(b) Address 1826 Eastern Avenue Huntingtown Williamsport, Md.

19 JUN 27 1947 (b) Registrar
(Date rec'd by registrar)

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26, 1947, at 7.05 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil H. Reyer M.D.
Medical Examiner

Date signed 6-26-47

C52953

BALTIMORE CITY HEALTH DEPARTMENT

CWK-110490

CERTIFICATE OF DEATH 587

Registered No. C52953

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Month

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2725 Round Road-Cherry Hill
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roberta Clementine Jenkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22-1931

8. AGE: Years	Months	Days	If less than one day
15	7	3	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name Alfred Jenkins

13. Birthplace Maryland

14. Maiden Name Ethel Barnes

15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals

(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof 6/30/47
(month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Mt Wainer

18 (a) Funeral director Harley & Abbruzzese

(b) Address 1200 McCulloh St.

19 (Date received) JUN 27 1947 (Registrar's signature) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1947, at 6:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 7 1947 to June 25 1947, and that I last saw her alive on June 25 1947

Immediate cause of death	Duration
Pericarditis, Rheumatic	2 weeks
Due to Pulmonary Congestion, Bilat	1 week
Due to Acute	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.

Address Balt. City Hosp. Date signed 6-26-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C52954

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C52954

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7075 ROCKROSE AVE.
(c) Hospital or institution: ARDLEIGH NURSING HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County ANNE ARUNDEL
(c) City or town SOLLEY (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME AUGUST HENRY ECKHARDT

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 2, 1871

8. AGE: Years 75 | Months 3 | Days 24 | If less than one day ... hr. ... min. 1872

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation RETIRED

11. Industry or business

FATHER 12. Name LOUIS ECKHARDT
13. Birthplace GERMANY

MOTHER 14. Maiden Name ELIZABETH KRATZ
15. Birthplace GERMANY

16 (a) Informant MRS A. WHITTIG
(b) Address 4210 FAIRVIEW RD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6 28 47 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location BALTO.

18 (a) Funeral director A. R. SLADE
(b) Address 4907 York Rd Huntington Hilliard, Md

19 (a) (Date) JUN 27 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 26 1947, at 6:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1947, to June 26 1947, and that I last saw h[illegible] alive on June 26 1947

Immediate cause of death	Duration
Hypostatic Pneumonia	
Due to	over
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

M.D.
Signature Edward G. Grossman
Address 2037 Falls Rd. Date signed 6/27/47

VS 150

G52955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G52955 Registered No. 1319

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2344 Wilkens Ave
(c) Hospital or institution: No

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2344 Wilkens Avenue
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME August Walter Simon

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 216-01-7232

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Julia A. Simon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 29, 1892

8. AGE: Years 54 | Months 5 | Days 28 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Butcher

11. Industry or business Ft. Roofing Co.

FATHER
12. Name John Simon
13. Birthplace Germany

MOTHER
14. Maiden Name Matilda Sadowsky
15. Birthplace Germany

16 (a) Informant Julia A. Simon
(b) Address 2344 Wilkens Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-30-47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director George L. Schwab
(b) Address 210 Hanlick Avenue
(c) Baltimore, Md.

JUL 1 1947
(Date rec'd by registrar)

Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26, 1947, at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/16/47 19 to 6/26 1947 and that I last saw h[illegible] alive on 6/26 1947.

Immediate cause of death: Acute Cardiac Failure — Duration: 1 Da

Due to: Cerebrovascular Renal Disease — Duration: yrs

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph A. Lawrence M.D.

Address 6 S. Washington Ave. Date signed 7/1/47

652956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164a

652956 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4940 Eastern Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph T. Craddock, Jr.

3 (b) If veteran, name war: W. W. #2

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married, widowed, or~~ divorced
Male	White	Divorced

6 (b) Name of ~~husband or~~ wife Arline Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1st 1901

8. AGE: Years	Months	Days	If less than one day
45	11	25	hr. min.

9. Birthplace Lynchburg Va.
(Town, county, and state)
10. Usual Occupation Patient
11. Industry or business Perry Point Hospital

FATHER
12. Name Joseph T. Craddock
13. Birthplace Lynchburg Va.

MOTHER
14. Maiden Name Ora Lavender
15. Birthplace Lynchburg Va.

16 (a) Informant Gertrude C. Traynham (Sister)
(b) Address High Point N.C.

17 (a) Removal (b) Date thereof 6/27/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Spring Hill
Location Lynchburg Va.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 (Date received) JUN 28 1947 (Registrar) Huntington Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 1947, at 6 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to hanging

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-26-47 at 5:45 P M.
(b) Where did injury occur? Central Police Station
(c) Did injury occur at home, on farm, industrial place, in public place? Jail While at work? (Outdoors)
(d) Means of injury Hanged with bicycle tire from

23. Signature Earl L. Cole M.D.
Medical Examiner.
Date signed 6-27-47

X

G52957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G52957

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rockwood & Towne Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 61
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Westport
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2420 Dorton Court #30
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Geffert, Henry F. E.

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Margaret E. Geffert nee Meeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1903

8. AGE: Years 44 | Months 4 | Days 12 | If less than one day hr. min.

9. Birthplace Reedsbury, Wisconsin
(Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business War Dept.

FATHER
12. Name Walter Geffert
13. Birthplace Wisconsin

MOTHER
14. Maiden Name Minnie T. Stiegler
15. Birthplace Maryland

16 (a) Informant Mrs. H. F. E. Geffert
(b) Address 2420 Dorton Court, Westport, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/28/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JUN 28 1947

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26th 1947, at 1:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 21 1947 to June 26 1947 and that I last saw him alive on June 26 1947

Immediate cause of death: Metastatic carcinoma of brain & adrenals — Duration

Due to: Primary ca — over

Due to:

Other Conditions: Hypoproteinemia, Severe
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard P. Holmes M. D.
Address Univ. Hosp. Date signed 6/26/47

X

G52958

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51 C

Registered No. G52958

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4310 Berger Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 4310 Berger Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELMER MOON

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lavina A. Moon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1, 1895

8. AGE: Years	Months	Days	If less than one day
51	8	25	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business S. S. O. A. B.

FATHER
12. Name Isaac P. Moon
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Laura Hartlove
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Lavina A. Moon
(b) Address 4310 Berger Ave.

17 (a) Burial (b) Date thereof 6/28/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Trinity Cem.
Location Baltimore, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 28 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26, 1947, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 23 1947, to June 26 1947 and that I last saw him alive on June 26 1947.

	Duration
Immediate cause of death: Cardiac failure	1 day.
Due to: Carcinoma of prostate with metastasis	4 mo.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Stephen J Van Lill III M. D.

Address 2843 St Paul St Date signed 6-27-47

X

G52959

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. G52959

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5500 Hilltop Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5500 Hilltop Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME A. Herman Larsen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Flora K. Larsen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29, 1873

8. AGE: Years	Months	Days	If less than one day
73	5	28	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Mail Carrier
11. Industry or business U. S. Govt.

FATHER
12. Name John Larsen
13. Birthplace Norway

MOTHER
14. Maiden Name Emilie Priebe
15. Birthplace Germany

16 (a) Informant Mrs. A. H. Larsen
(b) Address 5500 Hilltop Ave.

17 (a) burial (b) Date thereof June 20, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto., Md.

18 (a) Funeral director Lansdale Funeral Home
(b) Address 7401 Belair Road

19 (a) JUN 28 1947 Huntington Williams, M.D.
(Date received) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1947, at 10:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from January 10 1947, to June 27 1947, and that I last saw him alive on June 26 1947.

Immediate cause of death	Duration
Cerebral hemorrhage	2 days
Due to Cardio-vascular hypertensive disease.	3 years
Due to Arteriosclerosis	3 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Michael J. Ducsak M. D.
Address 1 W. Oversea Ave. Date signed 6-27-47

X

G52960

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G52960

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1614 Madison Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1614 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HESTER CLARK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife. ✓
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1, 1882

8. AGE: Years	Months	Days	If less than one day
65	3	26	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James W. Murray
13. Birthplace Md.

MOTHER
14. Maiden Name Caroline Scott
15. Birthplace Md.

16 (a) Informant Mr. George Murray
(b) Address 1614 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-29-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 570 W. Biddle St.

19 (a) JUN 28 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27, 1947, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-26- 1947 to 6-27- 1947, and that I last saw her alive on 6-27-47 19

Immediate cause of death	Duration
Cerebral apoplexy	
Due to Essential hypertension	3 0 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. A. Pendleton M. D.
Address 1723 Druid Hill Ave Date signed X 6 '47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B ✓

Registered No. G52961

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 818 S. Ponca St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 818 S. Ponca St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Frank X. Sporny

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Antonnia Gaskowska

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-30-1880

8. AGE: Years 67 | Months 8 | Days 26 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Pemco, Co.

FATHER
12. Name Joseph Sporny
13. Birthplace Poland

MOTHER
14. Maiden Name Anna Lewandouski
15 Birthplace Poland

16 (a) Informant Antonnia Sporny
(b) Address 826 S. Ponca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-30-47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Road

18 (a) Funeral director Lilly & Zeiler, Inc.
(b) Address 403 S. Wolfe St.

19 (a) JUN 28 1947 Received by registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1946 to June 26 1947 and that I last saw him alive on June 26 1947

Immediate cause of death: Cerebral Embolism

Due to: Metastasis of Prostatic Carcinoma

Duration: 8 yrs. 8 mos.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. B. Stevens M.D.

Address 3406 Edmondson Date signed 6/28/47

V S 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G52962

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 614 W. Lee
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 614 W. Lee St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elmer C. Gordon

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-16-1905

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/20/1926

8. AGE: Years 21 | Months 1 | Days 6 | If less than one day ... hr. ... min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER: 12. Name Harry Gordon
13. Birthplace Md

MOTHER: 14. Maiden Name Elsie Bush
15. Birthplace Md

16 (a) Informant Elsie Gordon
(b) Address 614 W Lee St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/29/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director James A. Stamper
(b) Address 142 W. Fayette St.

19 JUN 28 1947 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 1947, at 1:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/13 1947, to 6/26 1947, and that I last saw h[illegible] alive on 6/26 1947.

Immediate cause of death	Duration
Tuberculous Pulmonary	3 Weeks
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ralph A. Reckling, M.D.

Address 414 N. Calvert St Date signed 6/28/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G52963

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4042 Boarman Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4042 Boarman Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LeRoy Graydon

3 (b) If veteran, name war: 1st World War
3 (c) Social Security Account No. 214-16-3414

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Selma H. Graydon
6 (c) If alive, give age: 39 years
7. Birth date of deceased (mo., day, yr.): July 31, 1897
8. AGE: Years: 50 | Months: 10 | Days: 26 | If less than one day: hr. min.
9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Lead Burning Contractor
11. Industry or business:

FATHER
12. Name: Joseph G. Graydon
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Marion Biddle
15. Birthplace: Crompton, Md.

16 (a) Informant: Mrs. Leroy Graydon
(b) Address: 4042 Boarman Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 30, 1947 (month) (day) (year)
(c) Cemetery or crematory: National Cemetery
Location: Arlington, Va.
18 (a) Funeral director: Miller Lamstead
(b) Address: 4510 Liberty Heights Ave.

JUN 28 1947 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 26 1947, at 4.35A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jun 16 1947 to June 26 1947, and that I last saw h im alive on Jun 25 1947

Immediate cause of death: Laceration of Brain + Skull — Duration: 2 hours

Due to: Laceration of Brain + Skull

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation: June 1947
Major findings of operation: Laceration of Brain
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: A. C. Lamm M. D.
Address: 4509 Liberty Hgts Ave Date signed

X

G52964 Ford Cordtsiegle

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X ✓ 160a

G52964 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D-82032
(b) Street address Baltimore 2025 W. Fayette St.
(c) Hospital or institution:
Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt
(c) City or town Halethorpe (If outside city or town limits, write RURAL and give town)
(d) Street No. 1721 Sulphur Spring Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Stuart Wilderson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/25/47

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Horace Donald Wilderson
13. Birthplace Finksburg Md.

MOTHER
14. Maiden Name Catherine E Stuart
15. Birthplace Balto.

16 (a) Informant Horace D Wilderson
(b) Address 1721 Sulphur Spring Rd Halethorpe

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 28, 1947 (month) (day) (year)
(c) Cemetery or crematory Mount Cathedral
Location Old Frederick Rd

18 (a) Funeral director Harry H Witzke
(b) Address 4101 Edmondson ave

19 (a) JUN 28 1947 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1947 at 10 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 25 1947 to June 27 1947 and that I last saw him alive on June 27 1947

Immediate cause of death Intracranial hemorrhage ?

Due to not known

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

Duration 2 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter B. Sanger, M.D.
Address Bon Secours Hospital Date signed 6/27/47 M. D.

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians, please write the cause of death clearly and legibly.

C52965

BALTIMORE CITY HEALTH DEPARTMENT

BATEMAN

CERTIFICATE OF DEATH

50

Registered No. C52965

(OVER)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2924 W. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2924 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH OCTAVIA BATEMAN

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Cleveland W. Bateman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1888

8. AGE: Years (69) 58 | Months 11 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George E. Cavano
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Annie Griffin
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Lucille Mae Schreck
(b) Address 2924 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/29/47 (month) (day) (year)
(c) Cemetery or crematory Bethel Church of God Cem.
Location Carrollton, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 28 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27, 1947, at 6:45a M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 20 1946 to June 27 1947 and that I last saw her alive on Jun 26 1947

Immediate cause of death: Carcinoma with Metastasis — Duration: 6 yrs

Due to: Primary in Breast

Due to: Late — Pelvic bones

Other Conditions.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. H. Pearce M. D.

Address 405 N. Charles Date signed Jun 28/47

V S 150

G52966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G52966

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4811 Laurel Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4811 Laurel Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY STANLEY SUTTON

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife George E. Sutton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1869

8. AGE: Years	Months	Days	If less than one day
77	10	12	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Felix E. Brown
13. Birthplace Md.

MOTHER
14. Maiden Name Clara E. Milburn
15. Birthplace St. Mary's Co., Md.

16 (a) Informant Mrs. Marion S. Carpenter
(b) Address 4811 Laurel Ave.

17 (a) Burial (b) Date thereof 6/30/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 JUN 28 1947 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27, 1947, at 6:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1940 to June 1947 and that I last saw h er alive on June 20 1947

Immediate cause of death	Duration
Myocardial Insufficiency	5 yrs
Due to Arteriosclerosis	Ind.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John W. Carmody M. D.
Address 1109 St. Paul St. Date signed June 27, 1947

G52967

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G52967

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Chapel Gate Lane
(c) Hospital or institution: Provident Sanitarium
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 78 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Provident Sanitarium 800-A Chapel Gate Lane
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mary Emeline Schmenner

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: F

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 2, 1867

8. AGE: Years 79 | Months 10 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name J. Henry Schmenner
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Sarah Perkins
15. Birthplace Washington, D. C.

16 (a) Informant Mrs. Ella R. Schmenner
(b) Address 2950 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/30/47 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Baltimore, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUN 28 1947 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1947, at 10:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 20 1946, to June 27 1947, and that I last saw her alive on June 26 1947.

Immediate cause of death: Cerebral accident — Duration: 24 hr.
Due to: Cerebrovascular - renal disease
Due to:
Other Conditions: Healing fracture of tibia
(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) ~~Accident~~, suicide, or homicide Accident
(b) Date of occurrence January 1947 - a.m.
(c) Where did injury occur? Chapel Gate Lane Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public While at work? No
(Specify type of place)
(e) Means of injury Fell out of bed

23. Signature Howard J. Tenney M. D.
Address 5002 Frederick Rd. Balto. 3 Date signed 6-27-47

Howard J. Tenney, M.D.

G52968 JL - 103479

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH. 13B

Registered No. G52968

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 months
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 116 E. Chesapeake Ave. Towson
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Doris Coston

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1921

8. AGE: Years	Months	Days	If less than one day
25	11	29	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Coston
13. Birthplace ?

MOTHER
14. Maiden Name Ellen Stevenson
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof June 29-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Pleasant Rest
Location Towson Md.

18 (a) Funeral director Gibson Thomas McKnight
(b) Address 77 Wagner St. Balto. Md.

JUN 28 1947
(Date rec'd by registrar)

(b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1947; at 4.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-5 1946 to June 25 1947 and that I last saw her alive on June 25 1947

Immediate cause of death	Duration
Pulmonary Hemorrhage	
Due to Pulmonary Tuberculosis	1 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Not performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. Wright M. D.
Address Date signed 6-26-47

X

G52969 - VAKOUTIS -

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G52969

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1732 Thames St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Vakoutis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Sofkia

6 (c) If alive, give age: 7 years

7. Birth date of deceased (mo., day, yr.) 1-7-1894

8. AGE: Years 56 | Months 5 | Days 17 | If less than one day: min.
birthday

9. Birthplace: Greece (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Vakoutis
13. Birthplace Greece

MOTHER
14. Maiden Name Calopha Valia
15. Birthplace Greece

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-30-47 (month) (day) (year)
(c) Cemetery or crematory Beck Cemetery
Location Woodson Mill Rd.

18 (a) Funeral director Lambros Fun. Home
(b) Address 440 E. Monument Ave

19 (a) JUN 28 1947 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-26 1947, at 6:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 24 1947 to June 26 1947, and that I last saw h.(?) alive on June 26 1947.

Immediate cause of death: Syphilis Aortitis with Cardiac failure — Duration: 1½ yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. L. Dubois M. D.
Address Johns Hopkins Hospital Date signed 6-26-47

VS 150

G52970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G52970

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Halethorpe (If outside city or town limits, write RURAL and give town)
(d) Street No. 1903 Victory Drive (If rural give location)
(e) Citizen of foreign country? f (Yes or No)
If yes, name country

3 (a) FULL NAME Carmel Parone Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1933

8. AGE: Years	Months	Days	If less than one day
14	0	24	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Carmel Parone Sr.
13. Birthplace Md.

MOTHER 14. Maiden Name Dorothy Bell
15. Birthplace Md.

16 (a) Informant Carmel Parone
(b) Address 1903 Victory Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-30-47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director George A. Farley
(b) Address Taylor Ave. & Fay Blvd.

19 (a) JUN 28 1947 (Date rec'd by registrar) Huntington Williams M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-25-1947, at 7 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Its death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6/25/47 at 3:05 P.M.
(b) Where did injury occur? In quarry at Dwight's Woods Sulphur Springs
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Drowned while swimming

23. Signature Earl L. Kay M.D. Medical Examiner.
Date signed 6/26/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G52971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 1270

G52971
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner and Dukeland
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 16 days

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County Talbot
(c) City or town St. Michaels
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Anna I. Hunt

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Harvey M. Hunt
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug. 1893
8. AGE: Years 53 | Months 10 | Days | If less than one day ... hr. ... min.
9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John M. Hales
13. Birthplace Talbott Co.

MOTHER
14. Maiden Name Unknown
15. Birthplace Talbott Co

16 (a) Informant Harvey M. Hunt
(b) Address St. Michaels Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 1 (month) 47 (day) (year)
(c) Cemetery or crematory Christ Cemetery
Location St. Michaelsville Md
18 (a) Funeral director John O. Mitchell Sons
Address 29 W. Eutaw Place
19 (a) (b) (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 June 1947 at 1:00 P.M
21. I certify that death occurred on the date above stated; that I attended deceased from 12 June 1947 to 28 June 1947, and that I last saw h[illegible] alive on 28 June 1947.

Immediate cause of death: Pulmonary Embolism, Massive — Duration: 30 minutes
Due to: Phlebo-thrombosis, veins of legs — Duration: Unknown
Due to: Operation performed 16 June '47 (See Below) — Duration:
Other Conditions: Positive Kahn Test, Cholecystotomy and Appendectomy — Duration: Unknown
(Include pregnancy within 3 months of death)
Date of operation 16 June 47
Major findings of operation: Adhesions about gall bladder
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Julius W. Bell, M. D.
Address West Baltimore General Hospital Date signed 29 June 47

X

G52972

BALTIMORE CITY HEALTH DEPARTMENT X 157E

CERTIFICATE OF DEATH

G52972 Registered No.

MARGIN—RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Texas (b) County
(c) City or town Amarillo (If outside city or town limits, write RURAL and give town)
(d) Street No. 920 Bonham St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Whitney

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-20-40

8. AGE: Years 7 | Months 2 | Days 7 | If less than one day hr. min.

9. Birthplace Texas (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Knox Whitney
13. Birthplace Texas

MOTHER 14. Maiden Name Helen Bobbitt
15. Birthplace Texas

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof June 28/47 (month) (day) (year)
(c) Cemetery or crematory Rose Hill Memorial Park
Location Amarillo Tex

18 (a) Funeral director Welch Funeral Home
(b) Address 200 E Oldham St

19 (a) JUN 29 1947 (Date rec'd by registrar) (b) Clayton Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27, 1947, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 22 1947 to June 27 1947 and that I last saw him alive on June 27 1947.

Immediate cause of death: Cardiac Arrest — Duration: 5 min

Due to: Exploratory thoracotomy for coarctation of Aorta — Duration: 4

Due to:

Other Conditions: Congenital Heart Disease

(Include pregnancy within 3 months of death)

Date of operation 6/27/47

Major findings of operation: Coarctation of Aorta

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature Kenneth D. Johns, M. D.

Address Johns Hopkins Hosp. Date signed 6/27/47

X

G52973 — BALTIMORE CITY HEALTH DEPARTMENT — G52973 Registered No.

CERTIFICATE OF DEATH

X 83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State La (b) County
(c) City or town New Orleans (If outside city or town limits, write RURAL and give town)
(d) Street No. 2122 Treasury St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Stafford Stokes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Jeel O'Steen (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 26 1883

8. AGE: Years	Months	Days	If less than one day
63	8	-	hr. 18 93 min.

9. Birthplace Gainesville Fla (Town, county, and state)

10. Usual Occupation Marine Engineer

11. Industry or business

FATHER 12. Name Wm F Stokes

13. Birthplace S C

MOTHER 14. Maiden Name Lula W Stafford

15. Birthplace Fla

16 (a) Informant Mrs Stafford Stokes

(b) Address 2139 Treasure New Orleans

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof June 28 (month) (day) 1947 (year)

(c) Cemetery or crematory Ocala Fla

Location Ocala Fla

18 (a) Funeral director Ullen Funeral Home

(b) Address 2005 Orleans

19 (a) 29 1947 (Date rec'd by registrar) Lorington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 1947, at 8 55 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cerebral Edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Earl L Long M.D. Medical Examiner.

Date signed 6-27-47

G52974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G52974

Registered No. 94a

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2807 Ulman Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2807 Ulman Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Budnick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 76 | Months | Days | If less than one day hr. min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: Harry Alpert
13. Birthplace: Russia

MOTHER
14. Maiden Name: Fannie ?
15. Birthplace: Russia

16 (a) Informant: Isadore Budnick
(b) Address: 2807 Ulman Ave

17 (a) Burial (b) Date thereof June 29, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory: Hebrew Herring Run Cem
Location: Bowleys Lane

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

29 1947
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION 9.15

20. DATE OF DEATH June 27 1947, at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 27 1947 to June 27 1947, and that I last saw h[illegible] alive on June 27 1947.

Immediate cause of death: Coronary Thrombosis — Duration

Due to: Arteriosclerosis.

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Bertha A. Kalmanson M. D.
Address: 3700 Park Heights Ave Date signed June 27 1947

X

G52975

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

116

G52975
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Sinai Hospital
(b) Street address Monument & Rutland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2336 Reisterstown Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lena Abel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Phillip

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1877

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: David Mischel
13. Birthplace: Russia

MOTHER
14. Maiden Name: Pauline ?
15. Birthplace: Russia

16 (a) Informant: Mr Raphael Abel
(b) Address: 5615 Pimlico Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 29, 1947 (month) (day) (year)
(c) Cemetery or crematory: Bnai Israel Cemetery
Location: Southern Ave

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

19 (a) (Date received by registrar) JUN 29 1947 (b) Registrar: Hunnington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27th 1947, at 6:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 4 1947 to June 27 1947 and that I last saw her alive on June 27 1947

Immediate cause of death: Bronchopneumonia — Duration:
Due to: Aspiration from Fracture
Due to: calcified mediastinitis (?) tuberculous
Other Conditions: (over)
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Heinz Beissinger M.D.
Address: Sinai Hospital Date signed 6/27/47
M. D.

G52976 BALTIMORE CITY HEALTH DEPARTMENT G52976
CERTIFICATE OF DEATH 1170 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — Sinai Hospital
(b) Street address
(c) Hospital or institution: Monument & Rutland Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2601 Loyola Southway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Chai Miller

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Late Mottel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1847

8. AGE: Years	Months	Days	If less than one day
100			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business None

FATHER
12. Name Sander Mulzevitz
13. Birthplace Russia

MOTHER
14. Maiden Name Sadie Mulzevitz
15. Birthplace Russia

16 (a) Informant Michael Miller
(b) Address 4207 Maine Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 29, 1947 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cemetery
Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1126 N North Ave

JUN 29 1947 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-28 1947, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-14 1947, to 6-28 1947, and that I last saw her alive on 6-28 1947.

Immediate cause of death	Duration
Multiple ulcers of duodenum and stomach.	
Due to Arteriosclerotic Heart Disease	
Myocardial Insufficiency	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan B. Myerson M.D.
Address Sinai Hosp. Date signed 6-28-47

X

G52977

G52977

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/31a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1520 W. Lexington (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mabel Griffith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: James E. Griffith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 8, 1895

8. AGE: Years 51 | Months 8 | Days 19 | If less than one day hr. min.

9. Birthplace Magothy Maryland (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Edward Griffith
13. Birthplace Md

MOTHER 14. Maiden Name Harriet Strong
15. Birthplace Va

16 (a) Informant James E. Griffith
(b) Address 1520 W. Lexington st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 29 47 (month) (day) (year)
(c) Cemetery or crematory Magothy Cem
Location A.A. County Md

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna ave

19 (a) 6-29-1947 (Date received by registrar) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-27 1947 at 2:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-25 1947 to 6-27 1947 and that I last saw her alive on 6-27 1947.

Immediate cause of death	Duration
Uremia	
Due to Hypertensive Cardio Vascular Renal Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry McDonald

Address 844 W Carey st Date signed 6/28/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52977 — BALTIMORE CITY HEALTH DEPARTMENT — G52977 Registered No.

CERTIFICATE OF DEATH 1937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A. St. Josephs Hospital
(b) Street address 1724 N.Durham Street
(c) Hospital or institution: 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1724 N.Durham Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME James F.Brown

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 215-14-4554

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Margaret A.Dressel
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) April 3, 1897

8. AGE: Years 50 | Months 2 | Days 5 | If less than one day ######### min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Stationary Engineer
11. Industry or business Sparrows Point, Ship Yard

FATHER — 12. Name George Brown
FATHER — 13. Birthplace Baltimore, Md.
MOTHER — 14. Maiden Name Elizabeth [illegible]baugh
MOTHER — 15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Margaret A.Brown (Wife)
(b) Address 1724 N.Durham Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/1/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore County, Md.

18 (a) Funeral director George J.Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) Rec'd by (b) [illegible] Registrar

JUN 29 1947

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28th. 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-1-44 19__ to 6/28/47.
and that I last saw him alive on 6/14/47.

Immediate cause of death	Duration
Coronary Occlusion	1 hr.
Myocardial Dysmut	4 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature F. H. Hagerman M. D.
Address 1710 E. 33rd St. Date signed 6/28/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

G52979 — CERTIFICATE OF DEATH — 94a — Registered No. G52979

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 100 N.Linwood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days): None
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: City
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 100 N.Linwood Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: Winifred Kelly

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 13th 1882

8. AGE: Years: 64 | Months: 6 | Days: 14 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: At Home
11. Industry or business:

FATHER
12. Name: Patrick Kelly
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Mary Ann McClain
15. Birthplace: Baltimore, Md.

16 (a) Informant: Margaret F.Kelly (Sister
(b) Address: 100 N.Linwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 6/30/47 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Edmondson Avenue

18 (a) Funeral director: George J.Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) (Date rec'd by Registrar) Washington Wilkinson M.D. Registrar

JUN 29 1947

L S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 27th., 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 26 47 to June 29 1947 and that I last saw h[illegible] alive on June 27 1947

Immediate cause of death: Coronary Thrombosis — 1 day — Duration

Due to:

Due to:

Other Conditions: Senility

(Include pregnancy within 3 months of death)

Date of operation: none

Major findings of operation: none

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify home, farm, etc.)
(e) Means of injury:

23. Signature: B.O'Kelly M. D.

Address: 100 N.Linwood Ave. Date signed: June 29 47

X

G529[illegible] BALTIMORE CITY HEALTH DEPARTMENT G529[illegible]
CERTIFICATE OF DEATH 126 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkins Ave. & Gaston Ave
(c) Hospital or institution: St Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) Fatal

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 75 S. Monastery Ave (If rural give location)
(e) Citizen of foreign country? a. c. (Yes or No)
If yes, name country

3 (a) FULL NAME Dora Foreman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife John E. Foreman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 3-1871

8. AGE: Years 71 | Months 7 | Days 24 | If less than one day ____ hr. ____ min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Lary Hennerotte
13. Birthplace Hebbard,

MOTHER 14. Maiden Name Mickey Spriggs
15. Birthplace Ireland

16 (a) Informant Austin J. Foreman
(b) Address 52 S. Ellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/30/47 (month) (day) (year)
(c) Cemetery or crematory Leigh Hill
Location Baltimore County Md

18 (a) Funeral director F. B. Wippert Son
(b) Address 854 W. Baltimore St

19 (a) JUN 29 1947 (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 June 1947, at 1235A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7 June 1947 to 27 June 1947 and that I last saw her alive on 27 June 1947.

	Duration
Immediate cause of death Myocardial failure	
Due to Atelectasis & Pneumonitis	
Due to Post operative shock	
Other Conditions Cholelithiasis spont. Cholecystgastrostomy	

(Include pregnancy within 3 months of death)

Date of operation 17 June 47

Major findings of operation: spontaneous cholecystgastrostomy

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. E. McGrath M.D. M. D.
Address St Agnes Hosp Date signed

X 27 June 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52987 BH # B 33631

BALTIMORE CITY HEALTH DEPARTMENT X 107

CERTIFICATE OF DEATH

G52981 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens Ave
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Arbutus Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1315 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas E. Popp Jr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct. 6 1945

8. AGE: Years	Months	Days	If less than one day
1	8	27	— hr. — min.

9. Birthplace Maryland - Balto.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Thomas E. Popp, Sr.
13. Birthplace Maryland

MOTHER
14. Maiden Name Myrtle Lyke
15. Birthplace S. Dakota

16 (a) Informant Thomas E Popp Sr.
(b) Address 1315 Linden Ave - Arb

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 29 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director J. Bleistein & Son
(b) Address 1300 Eutaw Place

19 (a) (b)
(Date rec'd by registrar) Registrar

1947 VS 150 Huntington Williams, MD

JUN 29

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1947, at 4:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 26 1947 to June 28 1947 and that I last saw him alive on June 27 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to Pneumonia	
Due to Lobar pneumonia & Nephritis	over
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] MD

Address St Agnes Date signed 6/28/47

X

G52980 BALTIMORE CITY HEALTH DEPARTMENT G52980
Registered No.

CERTIFICATE OF DEATH 94a

MARGIN RESERVED FOR BINDING. WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1113 Forrest St
(c) Hospital or institution: 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1113 Forrest St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Agnes Ellwood

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Stephen Ellwood
13. Birthplace Ireland

MOTHER
14. Maiden Name Maria Lucy Lanahan
15. Birthplace Ireland

16 (a) Informant Miss Ellwood
(b) Address 1113 Forrest St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 30, 1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 East Biddle St

June 29 1947 (Date received by registrar) Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1947, at 3:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 26 1947, to June 27 1947, and that I last saw her alive on June 26 1947.

Immediate cause of death	Duration
Cardiac Failure	
Due to Myocardial Infarction	
Due to Coronary Thrombosis	
Other Conditions Generalized arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. Trulear M. D.
Address 2116 N. Pratt St. Date signed 6/28/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52983 — BALTIMORE CITY HEALTH DEPARTMENT — G52983 Registered No.

CERTIFICATE OF DEATH 117a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write Rural and give town)
(d) Street No. 3016 Chelsea Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Rosenberg

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Leah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1862

8. AGE: Years 85 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Poland

MOTHER
14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Samuel Rosenberg
(b) Address 3426 Royce Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-29-47 (month) (day) (year)
(c) Cemetery or crematory United Hebrew
Location Washington Boulevard

18 (a) Funeral director Jos. Levy Inc
(b) Address 1434 E Balto St

19 (a) (Date rec'd by registrar) JUN 29 1947 (Registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1947, at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 24 1947 to June 27 1947 and that I last saw him alive on June 27 1947.

Immediate cause of death: Coronic Failure — Duration
Due to: Arteriosclerosis
Due to: Myocardial Infarction
Other Conditions: Arteriosclerotic Heart Disease — Left Hemiplegia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jos. J. Mealy M. D.
Address Sinai Hospital Date signed 6-27-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52984 — BALTIMORE CITY HEALTH DEPARTMENT — G52982 Registered No.

CERTIFICATE OF DEATH 1117a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Salto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 60 S. Eutaw St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Edwards

3 (b) If veteran, name war

3 (c) Social Security Account No. 237-12-7914

4. Sex: M | 5. Color or race: C | 6 (a) Single, (married), widowed, or divorced.

6 (b) Name of husband or wife Maude

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30, 1901

8. AGE: Years 45 | Months 11 | Days 26 | If less than one day hr. min.

9. Birthplace Fayetteville, N. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Arthur Edward
13. Birthplace Fayetteville, N.C.

MOTHER 14. Maiden Name Mary J. McCuiere
15. Birthplace Fayetteville, N.C.

16 (a) Informant Maude Edwards
(b) Address 1103 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 29, 1947 (month) (day) (year)
(c) Cemetery or crematory Family Lot
Location Fayetteville, N.C.

18 (a) Funeral director Mr. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) (b)
(Date rec'd by registrar)

Registered
JUN 29 1947
Washington, Williams, Mgr

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/26/47 19 , at 6 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/26 1947 to 6/26 1947, and that I last saw him alive on 6/26 1947.

Immediate cause of death: Cardio Vascular Collapse — Duration:
Due to: Perforated Peptic Ulcer
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation: Perforated Peptic Ulcer
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Shallenberger Jr. M. D.
Address University Hospital Date signed 6/27/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

G52985

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 1937

G52985 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lauder Ave. + Madison St.
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 209 Wilden Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H Kernan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Eleanor Kernan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3 Feb 1869

8. AGE: Years 78 | Months 4 | Days 25 | If less than one day hr. min.

9. Birthplace Massachusetts (town, county and state)

10. Usual Occupation Retired Supt. Grain
11. Industry or business Orphans Home - Office etc

FATHER
12. Name Dennis Kernan
13. Birthplace Scotland

MOTHER
14. Maiden Name Mary Layden
15. Birthplace England

16 (a) Informant Mrs. Eleanor Kernan
(b) Address 209 Wilden Drive, Towson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 1, 1947 (month) (day) (year)
(c) Cemetery or crematory Green Lawn
Location Tiffin, Ohio

18 (a) Funeral director Miles Lanahan
(b) Address 4510 Liberty Heights Ave.

29 1947 (Date rec'd by registrar) (b)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 June 1947, at 11:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 20 June 1947 to 28 June 1947, and that I last saw h[illegible] alive on 28 June 1947

	Duration
Immediate cause of death: Coronary occlusion	3 days
Due to: Hypertensive Cardio-vascular disease	15 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature A. Allan Spear
Address Md. Gen. Hosp. Date signed June 29 (47)

G52986

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G52986
Registered No.

51746 / 186a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3023 Orlando Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Solomon Emanuel

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-4-71

8. AGE: Years 76 | Months 3 | Days 24 | If less than one day hr. min.

9. Birthplace England.
(Town, county, and state)

10. Usual Occupation Retired Printer

11. Industry or business

FATHER
12. Name Isaac Emanuel
13. Birthplace Germany.

MOTHER
14. Maiden Name Esther Shapiro
15. Birthplace Germany.

16 (a) Informant Reynolds
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Cremation (b) Date thereof 6/30/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto. Md.

18 (a) Funeral director Laird Funeral Home
(b) Address 924 Eutaw Pl.

19 (a) Date filed by registrar JUN 29 1947 (b)

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH June 28 1947 at 1.35 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 21 1947 to June 28 1947 and that I last saw him alive on June 28 1947,

Immediate cause of death: CEREBRAL ARTERIOSCLEROSIS — Duration

Due to

Due to

Other Conditions: FRACTURE LEFT HIP. POST-OPERATIVE.
(Include pregnancy within 3 months of death)

Date of operation 26 June 47

Major findings of operations: NONE, OTHER THAN FRACTURED HIP.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 27/5
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 6/21/47 at 1 30 a. M
(c) Where did injury occur? 3023 Orlando Ave Baltimore
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury: Fell to floor

23. Signature Edmund J. McDonnell M.D.
Address Johns Hopkins Hospital Date signed June 29 1947
Dr. of H.M.S. Hospital by Howard J. Rhoads, M.D.

G52983 — Registered No. G52983

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address MARLBOROUGH APTS.
(c) Hospital or institution:
14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City ~~or town~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Marlborough Apts.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME BENJAMIN HARRY ELLIOT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG 14, 1870

8. AGE: Years	Months	Days	If less than one day
76	10	14	hr. min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)

10. Usual Occupation RETIRED SHIRT

11. Industry or business SALESMAN

FATHER
12. Name ABRAHAM ELLIOT
13. Birthplace GERMANY

MOTHER
14. Maiden Name REGINA WEILLER
15. Birthplace GERMANY

16 (a) Informant REGINA D LEVI
(b) Address MARLBOROUGH APTS

17 (a) Burial (b) Date thereof 6/30/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Ohel Shalom
Location Balto. Md.

18 (a) Funeral director Harid Sondheim & Son
(b) Address 1902 Eutaw Place

19 (a) JUN 29 1947 (Date rec'd by Registrar) (b) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1947, at 5:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 15 1940 to JUNE 28 1947, and that I last saw HIM alive on JUNE 28 1947.

Immediate cause of death UREMIA Y PYELONEPHRITIS — Duration 48 hrs

Due to

Due to

Other Conditions Benign Prostatic Hypertrophy 10 YRS
Arteriosclerotic Cardio-vasc. Dis.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Elliot Williams M. D.
Address 1106 N. Calvert St. Date signed June 29, 1947

VS 150

G52988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G52988

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Broadway
(c) Hospital or institution: Sinai Aged Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. Sinai Aged Home (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3. (a) FULL NAME Eva Bruenbaum) Eva GRUENBAUM

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	WIDOWED

6 (b) Name of husband or wife Wolf Bruenbaum
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 8 1858

8. AGE: Years	Months	Days	If less than one day
89 yrs	6	21	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name ? Bendorf,
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown,
15. Birthplace Germany

16 (a) Informant Mr. Mark Bruenbaum
(b) Address 2445 Carlton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/1/47 (month) (day) (year)
(c) Cemetery or crematory Chevt Shalom
Location Balto, Md.

18 (c) Funeral director Harry Goodstein & Son
(b) Address 702 Eutaw Place

19 (a) JUN 29 1947 (b) (Date rec'd by registrar) Clayton Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-29 1947 at 9:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-28 1947 to 6-29 1947, and that I last saw h[illegible] alive on 6-29 1947

Immediate cause of death Coronary occlusion, myocardial infarction

Due to arteriosclerotic heart disease

Due to

Other Conditions Carcinoma of breast

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elliott F. Weitzman M.D. M. D.
Address Sinai Hosp Date signed 6-29-47

93D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G52989 Registered No. 2698

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1035 N. Stricker St.
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1035 Stricker St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mary Elliott

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: colored
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Edward Elliott
6 (c) If alive, give age: 50 years
7. Birth date of deceased (mo., day, yr.): 8-29-1905
8. AGE: Years: 41 | Months: 9 | Days: 26 | If less than one day: hr. min.
9. Birthplace: Greenville N.C. (Town, county, and state)
10. Usual Occupation: Home wife
11. Industry or business: own home

FATHER
12. Name: Noah L. Hardy
13. Birthplace: N.C.

MOTHER
14. Maiden Name: Elizabeth ?
15. Birthplace: N.C.

16 (a) Informant: Edward Elliott
(b) Address: 1035 N. Stricker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/29/47 (month) (day) (year)
(c) Cemetery or crematory: Arbutus Mem'l. Pk.
Location: Balto. County, Md.

18 (a) Funeral director: Charles G. Cooper
(b) Address: 510-12 N. Carrollton Ave.

JUN 29 1947 (Date Rec'd by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-25 1947, at 8:26 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-4-1947 to 6-25-1947 and that I last saw h[illegible] alive on 6-25 1947.

Immediate cause of death: Carcinoma of Liver — Duration: unknown
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Frank A. Saunders M. D.
Address: 1029 N. Stricker St. Date signed 6-27-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146B

G52998 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey St.
(c) Hospital or institution: Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 yr
(e) Length of stay in Baltimore (yrs., mos., or days) probably life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Queen Anne's
(c) City or town Queen Anne
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME Altha Coulby (ALTHEA ADAMS COLBY)
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widow
6 (b) Name of husband or wife Robt M. Colby
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) July 8 1862
8. AGE: Years 84 Months 11 Days 19 If less than one day hr. min.
9. Birthplace Talbot County Md
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Wm. J. Adams
13. Birthplace Md.

MOTHER
14. Maiden Name — ? — Rose.
15. Birthplace Maryland

16 (a) Informant Robt. Colby - son
(b) Address 26 12 N. Calvert St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-30-47 (month) (day) (year)
(c) Cemetery or crematory Springhill
Location Easton Md.
18 (a) Funeral director Ellis Clark
(b) Address Easton Md.
(c) 6 29 1947 (d) Date received by registrar Easton Md.

VS 8

MEDICAL CERTIFICATION 19

20. DATE OF DEATH June 27 1947, at 7 P. M.
21. I certify that death occurred on the date above stated; that I attended deceased from June 23 1947 to June 27 1947, and that I last saw her alive on June 27 1947.

Immediate cause of death: Carcinoma of Stomach — Duration 1 yr
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Melton L. Solomon M. D.
Address 124 S. Broadway Date signed 6/27/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct spelling is especially important. Physicians: please write the causes of death clearly and legibly.

G52999 — BALTIMORE CITY HEALTH DEPARTMENT — G52999

CERTIFICATE OF DEATH

X 108

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: South Baltimore Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Pasadena (If outside city or town limits, write RURAL and give town)
(d) Street No. Old Annapolis Rd. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No) /
If yes, name country .....

3 (a) FULL NAME Delores Wilson

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex F | 5. Color or race W.C. | 6 (a) Single, married, widowed, or divorced. .....

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1936

8. AGE: Years 11 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER
12. Name Leroy Jones
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Frances Wilson
15. Birthplace Baltimore Md

16 (a) Informant Frances Wilson
(b) Address 1304 Jefferson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 30. 1942 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem.
Location Arnolds Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1005 Bentley ave

19 (a) JUN 29 1947 (Date rec'd by registrar) (b) Hampton Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-25- 1947, at 4 30 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Lobar pneumonia

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 6-26-47

X

G52992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G52992

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore -Essex-
(If outside city or town limits, write RURAL and give town)
(d) Street No. Round Road, Route #16
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES MEYERS

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	M

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1925

8. AGE: Years	Months	Days	If less than one day
22			hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Labor
11. Industry or business

FATHER
12. Name John H Meyers
13. Birthplace Sorley Md

MOTHER
14. Maiden Name Katie Meyers
15. Birthplace Back River Md

16 (a) Informant John H. Meyers
(b) Address Round Road Route #16

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 29 1947 (month) (day) (year)
(c) Cemetery or crematory St Seavens
Location Back River Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1010 Bentley Ave

19 (a) JUN 29 1947 (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25, 1947 at 1.05 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Intracranial hemorrhage.
Contusion of brain.
Bronchopneumania.
Fracture left clavicle

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-23-47 9 P. M.
(b) Where did injury occur? Mars Road & Eastern Ave. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Rider on bicycle struck auto

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 6-25-47

Huntington Williams, M.D.

G52993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 50

G52993 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 406 E. Clement
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 406 E. Clement
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Carmelita Quinn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1-1903

8. AGE: Years	Months	Days	If less than one day
43	11	16	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Quinn
13. Birthplace Ireland

MOTHER
14. Maiden Name Sarah A. Conger
15. Birthplace Baltimore Md.

16 (a) Informant Marguerite M. Quinn
(b) Address 406 E. Clement St.

17 (a) Burial (b) Date thereof 6-30-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md.

18 (a) Funeral director Flynn & Flemming
(b) Address 1426 Light St.

19 (a) 29 1947 (Date received by registrar) Kenneth Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26- 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/2 1947 to 6/26 1947 and that I last saw h alive on 6/26/1947.

Immediate cause of death — Coronary Thrombosis
Due to Arteriosclerosis
Due to
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

Duration
12 mo.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. D. Metcalfe M.D.
Address 1779 William St. Date signed 6/26/47

G52994

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 112

G52994 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 Jackson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Preston J. Frampton
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug 18, 1893

8. AGE: Years	Months	Days	If less than one day
53	10	11	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Frampton
13. Birthplace Maryland

MOTHER
14. Maiden Name Gertrude Jones
15. Birthplace Maryland

16 (a) Informant Martha Parrish
(b) Address 1618 Jackson St.

17 (a) Burial (b) Date thereof 7-2-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lutheran MdE.
Location Guilford Elliot Co

18 (a) Funeral director J. Inman Marshall
(b) Address St. Michaels Md.

JUN 9 1947
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-29- 1947 at 8. A.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 27 1947, to June 29 1947, and that I last saw him alive on June 27 1947

Immediate cause of death	Duration
acute Cardiac Failure	
Due to Status asthmaticus	
Due to chronic Bronchial Asthma	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles R. MacDonald M.D.
Address 1213 Light Street Date signed 6/29/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G52995 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 116 N Hilton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 116 N Hilton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Elwood Grein

3 (b) If veteran, name war NC

3 (c) Social Security Account No. 242-07-6118

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Viola C

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 23 1887

8. AGE: Years 59 | Months 7 | Days 3 | If less than one day hr. min.

9. Birthplace Parkton Md (Town, county, and state)

10. Usual Occupation Gas Fitter

11. Industry or business Gas & Electric Co

FATHER
12. Name Milton Grein
13. Birthplace Pittsburgh Pa

MOTHER
14. Maiden Name Elizabeth Arnold
15. Birthplace Glenburn Pa.

16 (a) Informant Viola Grein
(b) Address 116 N Hilton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/1/47 (month) (day) (year)

(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Milton Gotwals
(b) Address 1214 Harford St

JUN 30 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1947 at 5-15 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 1947 to June 28 1947 and that I last saw h alive on June 27 1947

Immediate cause of death: Cardiac failure — Duration 3 days

Due to Coronary Thrombosis — 6 weeks

Due to

Other Conditions Hypertension; Diabetes Mellitus; Arthritis — Years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leonard Groff

Address 300 W Baltimore St. Date signed 6/28/47

G52996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G52996 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 14 W N. Carolina St
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 dy
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County:
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 719 McHenry St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Lowman

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-2335

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 27 1908

8. AGE: Years 39 | Months 10 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore County Md. (Town, county, and state)

10. Usual Occupation Pay Master - Cashier

11. Industry or business Balto News Post

FATHER
12. Name Wm T. Lowman
13. Birthplace Md.

MOTHER
14. Maiden Name Clara Enzy Short
15. Birthplace U.A.C. Md.

16 (a) Informant Pearl Morris
(b) Address 719 Mc Henry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/1/47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director Williams Cook Inc
(b) Address 1217 St. Paul St

19 JUN 30 1947 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-27 1947, at 1130 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-27 1947 to 6-27 1947 and that I last saw her alive on 6-27 1947.

Immediate cause of death Spontaneous Subarachnoid Haemorrhage — Duration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John B Wells M.D. M. D.
Address Johns Hop Date signed 6-27-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

652997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 652997

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 416 E. Caroline St
(c) Hospital or institution: St Joseph's Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town 416 East 22nd St
(If outside city or town limits, write RURAL and give town)
(d) Street No. 416
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick L. Shipley

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-8738

4. Sex M | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 17th 1879

8. AGE: Years 67 | Months 9 | Days 10 | If less than one day hr. min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)

10. Usual Occupation Shipping Clerk

11. Industry or business Lyon Conklin

FATHER
12. Name Joseph Shipley
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Honora Laysgon
15. Birthplace Ohio

16 (a) Informant Genevieve Shipley
(b) Address 416 E. 22nd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/1/47 (month) (day) (year)
(c) Cemetery or crematory St. Johns
Location Long Green Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St Paul St

19 JUN 30 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-27 1947 at 12 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-27 1947 to 6-27 1947 and that I last saw h[illegible] alive on 6/27/47 1947

Immediate cause of death	Duration
Coronary Thrombosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John B Wolff M.D.
Address 416 E Jo Hosp Date signed 6-27-47

G52998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G52998 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 303 N. Pulaski St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John C. Huthwalker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married
M	W	

6 (b) Name of ~~husband or~~ wife Mabel M. Huthwalker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6th 1906

8. AGE: Years	Months	Days	If less than one day
40	11	19 21	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Pharmacist
11. Industry or business Ruxton Pharmacy

FATHER
12. Name John C. Huthwalker
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Emma Liet
15. Birthplace Balto. Md.

16 (a) Informant Mabel M. Huthwalker
(b) Address 303 N. Pulaski St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 1st 1947 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director Williams Cook Inc
(b) Address 127 St. Paul St.

19 (a) JUN 30 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-27-1947, at 7 45 P. M

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Its death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull & intracranial Hemorrhage

Due to

Other Conditions Acute gastritis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following: 15/4

(a) Date of injury 11:30 A at 6-27-47 M.
(b) Where did injury occur? Inside 2322 W. North Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial Pl. While at work? Yes
(d) Means of injury: Fell to floor striking head

23. Signature Emil L. Kruger M.D. Medical Examiner.
Date signed 6-28-47

VS 181

G52999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G52999

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2630 Park Heights Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2630 Park Heights Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Balser

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Louis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years 81 | Months | Days | If less than one day hr. min.

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name unknown
13. Birthplace Lith

MOTHER — 14. Maiden Name unknown
15. Birthplace Lith

16 (a) Informant Harry Balser
(b) Address 2630 Park Heights Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-30-47 (month) (day) (year)
(c) Cemetery or crematory
Location Shepherd Herring Lane

18 (a) Funeral director Jack Leifus Inc
(b) Address 1409 E Balto St

19 JUN 30 1947 Huntington Williams Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-29- 1947, at 10A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1934 to 6-29 1947.
and that I last saw her alive on 6-29, 1947.

	Duration
Immediate cause of death Apoplexy	6 days
Due to Bronchopneumonia	4 days
Due to Generalized Arteriosclerosis	15 yrs 30 yrs
Due to Diabetes Mellitus	20 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jacob Cohen M. D.
Address 1804 Eutaw Place Date signed 6-30-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G53000

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2009 Wilkens Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY GOLDBERG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Philip
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Sarah Goldberg
(b) Address 2009 Wilkens ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-30-47 (month) (day) (year)
(c) Cemetery or crematory United Hebrew
Location Washington Boulevard

18 (a) Funeral director Jack Lewis Inc
(b) Address 1139 E Balto St

19 JUN 30 1947 Registrar for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/29/47 1947, at 5:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/15 1947 to 6/29 1947, and that I last saw him alive on 6/29 1947.

Immediate cause of death MYOCARDIAL INFARCTION — Duration

Due to CORONARY ARTERIO-SCLEROSIS

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Albert Gerbutsky
Address 2008 W. North Ave Date signed 6/30/47 M. D.

G53001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

126

G53001

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, M-
(b) Street address 2 2 He + Calhoun Sts.
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2545 Laurella Ave
(If rural give location)
(e) Citizen of foreign country? N. D (Yes or No)
If yes, name country

3 (a) **FULL NAME** BERTHA Thomas.

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Geo. Thomas.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6 June 1898

8. AGE: Years 49 | Months | Days 22 | If less than one day hr. min.

9. Birthplace Maryland. Balto.
(Town, county, and state)

10. Usual Occupation House work
11. Industry or business at home

FATHER 12. Name James. E. WARE
13. Birthplace Maryland. Balto.

MOTHER 14. Maiden Name CORA Bent
15. Birthplace Maryland. Balto

16 (a) Informant Mr George Thomas
(b) Address 2545 Laurella Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/1/47 (month) (day) (year)
(c) Cemetery or crematory London Park Cem
Location 3801 Frederick Ave

18 (a) Funeral director John J. Cooper & Son
(b) Address 2101-23 Whitelock St

19 (a) [illegible] (Local registrar) (b) Huntington Williams M.D. Registrar

JUN 30 1947

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 June 1947, at 11:40 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 23 June 1947, to 6/28 1947, and that I last saw h[illegible] alive on 6/28 1947.

Immediate cause of death: Pulmonary Embolus. — Duration 24 hrs.

Due to: Cholelithiasis & obstructive jaundice — Duration 4 years

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 6/26/47

Major findings of operation: Cholelithiasis & obstructive jaundice

Date of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stanley B. Klyanowski M.D.
Address Franklin Sq. Hosp. Date signed 6/28/47

G53002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

120a

Registered No. G53002

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1814 N Spring St

(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1814 N Spring St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Parks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11 - 1883

8. AGE: Years 63 64 | Months 7 | Days 23 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name William Parks Sr

13. Birthplace Md

MOTHER 14. Maiden Name Mary Griffin

15. Birthplace Md

16 (a) Informant Georgia Jones

(b) Address 1814 N. Spring St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 30 47 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location A. G. Co

18 (a) Funeral director Rayner Sanders

(b) Address 1412 E. Preston St

19 (a) (b) Huntington Williams, M.D. Registrar

JUN 30 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1947 at 12 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6 24 1947 to 6 27 1947 and that I last saw h alive on 6 27 1947

Immediate cause of death: Acute Dilatation of Heart — Duration: 1 day

Due to: Acute Gastritis — 3 days

Due to: Enteritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)

(e) Means of injury

23. Signature Wm. A. Lowry M. D.

Address 1420 E. Chase Date signed 6 30 47

X

G53003

G53003 Bl#G-76326

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 154B

G53003 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline St.
(c) Hospital or institution St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 9.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1923 Gough St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Nukolezak

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	child.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16-1947

8. AGE: Years	Months	Days	If less than one day
0	2	12	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Elmer F. Nukolezak
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Bertha R. Kulik
15. Birthplace Born Balto Md

16 (a) Informant Mrs Bertha Nukolezak
(b) Address 1923 Gough st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-30-47 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore Md

18 (a) Funeral director George A Weber
(b) Address 705 S Ann

19 (a) JUN 30 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1947 at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 30 1947, to June 28 1947 and that I last saw him alive on June 26 1947

Immediate cause of death Cardio-Respiratory Failure — Duration

Due to Septicemia (Hemolytic Staph. aureus.

Due to

Other Conditions Osteomyelitis of Rt. tibia. (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy None Stated

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Anthony J. DiPaula M. D.
Address St. Joseph's Hosp. Date signed 6/28/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 125B

Registered No. G53004

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 636 S. Montford ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Hossa — Anthony Hossa

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-5263

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband/wife: Katherine

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) 5-19-89

8. AGE: Years 65 | Months 1 | Days 10 | If less than one day: hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Bethlehem Steel Corp.

FATHER
12. Name John HOSSA
13. Birthplace Poland

MOTHER
14. Maiden Name Antonina Polanowski
15. Birthplace poland

16 (a) Informant Mrs Katherine Hossa
(b) Address 636 S Montford ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-2-47 (month) (day) (year)
(c) Cemetery or crematory Mt Stanislaus
Location Baltimore Md

18 (a) Funeral director George A Weber
(b) Address 705 S Conkling

19 (a) JUN 30 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-29 1947, at 3:4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-18 19[illegible], to 6-29 1947, and that I last saw h[illegible] alive on 6-28 1947.

Immediate cause of death	Duration
T.B. Pneumonia, primary	
Due to Tuberculosis Abscess	
Due to [illegible]	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. E. Hanley M. D.
Address University Hosp Date signed 6-29-47

VS 150

G53005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c

G53005

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2006 Duker Court
(c) Hospital or institution:
Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-31,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2006 Duker Court
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Josephine Sachczynski (or) Sinsky

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-3054

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband ~~[illegible]~~ James
6 (c) If alive, give age Deceased

7. Birth date of deceased (mo., day, yr.) March 4-1878 ?

8. AGE: Years	Months	Days	If less than one day
69	3	24	....hr. ....min.

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Lorek
13. Birthplace Poland.

MOTHER
14. Maiden Name Mary Mrowczynski
15. Birthplace Poland

16 (a) Informant Helen Reitz (Daughter)
(b) Address 2019 E. Pratt Street

17 (a) Burial (b) Date thereof 7-1-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A Weber
(b) Address 705 South Ann Street

19 (a) JUN 30 1947 [illegible] Registrar
(b) Registrar's address

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28th 1947, at 12 30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 4 1947, to June 28 1947, and that I last saw h[illegible] alive on June 27 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage - Fract Chronic Myocarditis	6 mos - 2 yrs
Due to	
Due to	
Other Conditions Rheumatoid Arthritis	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify home, farm, or place) While at work?
(e) Means of injury

23. Signature Leo D. Lipsky
Address Patterson Park Ave Date signed 6/30/47

VS 3

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53006

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

108

G53006 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address West Baltimore General Hosp
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 9
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3800 Chatham Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME MOSES ROSEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Sarah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1873

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name Isaac Rosen
13. Birthplace Russia

MOTHER
14. Maiden Name Goldie Minnie
15. Birthplace Russia

16 (a) Informant Mrs Sarah Rosen
(b) Address 3800 Chatham Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 30, 1947 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) JUN 30 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar (b) Address

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/29 1947 at 2 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/8 1947 to 6/29 1947, and that I last saw h alive on 6/29 1947.

Immediate cause of death BILATERAL LOBAR PNEUMONIA — Duration

Due to

Due to

Other Condition CORONARY ARTERIOSCLEROSIS CHRONIC ULCER OF STOMACH
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Fabrikant, M.D.
Address 2008 W. North Ave Date signed 6/30/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G53007

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 531 Chateau Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 531 Chateau Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H. Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Clara E. Miller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25-1872

8. AGE: Years 74 | Months 8 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Watchmaker

11. Industry or business

FATHER
12. Name Henry C. Miller
13. Birthplace Germany.

MOTHER
14. Maiden Name Huckenbown
15. Birthplace Balto. Md.

16 (a) Informant Miss Edna M. Miller
(b) Address 531 Chateau Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 1-1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore

16 (a) Funeral director Maguire Co. & Syfer
(b) Address 1600 W. North Ave.

JUN 30 1947 (Date rec'd by registrar) (by Huntington for Williams, M.D.)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1947, at 9-20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 to June 28 1947 and that I last saw him alive on June 27 1947.

	Duration
Immediate cause of death Coronary Thrombosis	
Due to Coronary Atherosclerosis	4 years
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Fusting

Address 11 E. Chase St Date signed 6/28/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G53008

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 721 E. 21st Street
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 721 E. 21st Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARTHA LILLIAN HAWKINS

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	216-01-8554

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife William Edward Hawkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 20, 1876

8. AGE: Years	Months	Days	If less than one day
70	8	7	hr. min.

9. Birthplace Sharptown, Md.
(Town, county, and state)
10. Usual Occupation Dress maker - retired
11. Industry or business

FATHER
12. Name Saulsbury Thomas Andrews
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine Stanton
15. Birthplace Md.

16 (a) Informant Miss Kathryn A. Hawkins
(b) Address 721 E. 21st Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/30/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (c) JUN 30 1947 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27, 1947, at 5:30a M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1947, to June 27 1947 and that I last saw him alive on June 26 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to Arteriosclerotic Cardio-Vascular Disease.	
Due to	
Other Conditions Fracture of Left Leg	

(Include pregnancy within 3 months of death)
Date of operation May 20 47
Major findings of operation: Fracture neck of femur.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 9/8
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 5-14-47 at ? M
(c) Where did injury occur? 721 E 21st Street
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? no
(Specify type of place)
(e) Means of injury Albert Seagrotta

23. Signature 1725 N. Longwood St
Means of injury: Upper - fell a flight
Address Date signed 6/28/47
Howard J. Andelis, M.D.

V S 150

G53009

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. G53009

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1328 N. Eddwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1315 N. Montford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Wild
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John A. Wild
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5 1868

8. AGE: Years	Months	Days	If less than one day
79		24	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Mr. Greenbauer
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Pauline Michel
(b) Address 1315 N Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-2-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director John O'Neill Jr
(b) Address 2435 E Oliver St

19 (a) JUN 30 1947 Huntington Williams, M.D. (b) Address 3402 Eastern Ave

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1947 to June 29 1947 and that I last saw her alive on June 28 1947.

Immediate cause of death: Cerebral Thrombosis — Duration 2 wks.
Due to: Arteriosclerotic Cardio-Vascular Disease
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. B. Williams M.D.
Address 3402 Eastern Ave Date signed 6/30/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53010

411358 436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 80a

G53010

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State PENN. (b) County
(c) City or town MANNSchoice (If outside city or town limits, write RURAL and give town)
(d) Street No. R.D. #1 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Stockenis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	married

6 (b) Name of husband or wife Irene Stockenis

6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) 4-2-04

8. AGE: Years	Months	Days	If less than one day
43	2	28	hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name John Stockenis
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary Cuppett
15. Birthplace Pa.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof 6/30/47 (month) (day) (year)
(c) Cemetery or crematory Mount Olivet
Location Mount Olivet Pa.

18 (a) Funeral director John D Mitchell Funeral
(b) Address 4900 Eastern Ave.

19 JUN 30 1947 (Date rec'd by registrar) (b) Huddington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1947 at 12 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-28- 1947 to 6-30 1947 and that I last saw him alive on 6-30- 1947.

Immediate cause of death	Duration
Brain Abscess	2wks
Due to	
Due to Operation for Suspected	
Other Conditions Brain Tumor	

(Include pregnancy within 3 months of death)

Date of operation 6-28-47

Major findings of operations Brain abscess

of autopsy Same, No tumor

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
Signature A. B. Mouser, M.D. M. D.
Address 1114 Date signed 6-30-47

VS 150

X

G53011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G53011

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. CAREFULLY REVIEWED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4635 Falls Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 4635 Falls Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Scott Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Samuel L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1902

8. AGE: Years 75 | Months 1 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Rd. L. A. White

13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Henrietta Hankins

15. Birthplace Frederick, Md.

16 (a) Informant Samuel L. Brown

(b) Address 4635 Falls Rd.

17 (a) Burial (b) Date thereof 6/30/1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn Mem. Pk.

Location Baltimore Co. Md.

18 (a) Funeral director Chas. A. Stallard

(b) Address 1612 Druid Hill Ave.

19 (a) JUN 30 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/27/1947 at 11:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/19 1947 to 6/27 1947 and that I last saw her alive on 6/26/1947.

Immediate cause of death	Duration
Uremia due to	
Due to	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. F. Howell M.D.

Address 601 E. Lexington St. Date signed 6/31/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53012

BALTIMORE CITY HEALTH DEPARTMENT ✓ G53012

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 33

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1002 Mosher St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Floyd Raymond Ford Sr.

3 (b) If veteran, name war No

3 (c) Social Security Account No.

4. Sex M

5. Color or race Negro

6 (a) Single, married, widowed, or divorced. Seperated

6 (b) Name of husband or wife Myrtle Ford

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) June 3 1901

8. AGE: Years 46 Months Days 28 If less than one day ... hr. ... min.

9. Birthplace Keysville Va. (Town, county, and state)

10. Usual Occupation Presser

11. Industry or business None

FATHER 12. Name John Ford

13. Birthplace Keysville Va.

MOTHER 14. Maiden Name Mary Sosie Henderson

15. Birthplace Keysville Va

16 (a) Informant Wife

(b) Address 1100 Whitelock

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6 30 47 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn Cem

Location Balto Co. Md

18 (a) Funeral director Mrs. Geo. H. Holden

(b) Address 1631 Druid Hill Ave

19 (a) JUN 30 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/26/47 1947 at 12 05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/26 1947 to 6/26 1947 and that I last saw h[illegible] alive on 6/26 1947

Immediate cause of death Subarachnoid Hemorrhage — Duration ...

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. K. Adams M. D.

Address 1222 N. Caroline St Date signed

VS 150

X 6-28-47

G53013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G53013

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton + Wilkens ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3211 W. Rogers ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank E. Smith.

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M.

6 (b) Name of husband or wife: Gaynell Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28 1896

8. AGE: Years	Months	Days	If less than one day
50	-	-	hr. min.

9. Birthplace (State) Balto Md (Town, county, and state)
10. Usual Occupation Asst. Chief Atty
11. Industry or business Vet Admin.

FATHER
12. Name Edward Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Regina Bishop.
15. Birthplace Md.

16 (a) Informant Gaynell G. Smith
(b) Address 3211 W Rogers Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 2 1947 (Months) (day) (year)
(c) Cemetery or crematory Bait National
Location Baltimore Md

18 (a) Funeral director Harry J. Armacost
(b) Address 4204 Pittsworth Ave

19 (a) June 30 1947 Torrington, Maryland

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-28- 1947, at 11 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/25 1947 to 6/28 1947, and that I last saw him alive on 6/28 1947.

Immediate cause of death	Duration
Cerebral hemorrhage, left	4 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: cerebral hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hubert J. Lenickas
Address St Agnes Hosp Date signed 6/29/47

G53014

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

14

Registered No. G53014

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hosp. 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 4
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 279 W. Hoffman St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Savannah Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	B	M

6 (b) Name of husband or wife Wilmer Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1910

8. AGE: Years	Months	Days	If less than one day
37			hr. min.

9. Birthplace Alabama (Town, county, and state)
10. Usual Occupation Laundress
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name Smatter ?
15. Birthplace

16 (a) Informant Joanna Streeter
(b) Address 3767 Walden Ave

17 (a) Burial (b) Date thereof 7/1/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ~~Mt Calvary~~
Location Montgomery - Ala

18 (a) Funeral director Adolphus Sylestine
(b) Address 218 Druid Hill Ave.

19 JUN 30 1947 (b) Huntington Williamson, M.D.
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/25 1947, at 7 05 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 6/23 1947 to 6/25 1947, and that I last saw her alive on 6/25 1947.

Immediate cause of death Cardio-resp. failure — Duration

Due to Meningitis - Type undetermined

Due to

Other Conditions Pregnant - 32 wks.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Possible Meningitis (Pregnancy)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edwin A. Jennings M. D.
Address Univ. Hosp. Date signed 6/26/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DO NOT WRITE IN SPACE RESERVED FOR BINDING

G53015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓93c

G53015 Registered No.

The PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 130 WEST PRESTON STREET.
(c) Hospital or institution:
NO
(d) Length of stay in hospital or inst. (yrs., mos., or days) NO
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY
(If outside city or town limits, write RURAL and give town)
(d) Street No. 130 WEST PRESTON STREET. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MARY EPPS.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 21, 1895

8. AGE: Years 52 | Months 2 | Days 6 | If less than one day hr. min.

9. Birthplace Detroit, Michigan (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name ?

13. Birthplace Michigan

MOTHER 14. Maiden Name ?

15. Birthplace Michigan

16 (a) Informant John Taylor (Son)

(b) Address 130 W. Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-1-47 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Adolphus Halstead

(b) Address 918 Druid Hill Ave.

19 (a) JUN 30 1947 (Filed by registrar) Huntington W... Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH JUNE 27 1947 19 at 11.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT. 21 19 46 to JUNE 27 19 47 and that I last saw her alive on JUNE 27 19 47.

Immediate cause of death	Duration
CHRONIC MYOCARDITIS. SEPT. 21	1946.
Due to (RHEUMATISM) ARTERIOR SCLEROSIS.	1946.
Due to	
Other Conditions NONE	

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation: NONE

of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ernest Williams
Address 3013 ST PAUL STREET JUNE 27 1947.
Date signed

~~G53016~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G53016

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2124 E. Jefferson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 3
(e) Length of stay in Baltimore (yrs., mos., or days) 57yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town, write RURAL and give town)
(d) Street No. 2124 E. Jefferson St (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mabel Antos

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-6542

4. Sex Female

5. Color or race W.

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Leo Antos

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 4 1883

8. AGE: Years 63 | Months 8 | Days 24 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laundry work

11. Industry or business

FATHER 12. Name — ? McLer

13. Birthplace

MOTHER 14. Maiden Name Elizabeth Eison

15. Birthplace

16 (a) Informant Mr. Leo Antos

(b) Address 2124 E. Jefferson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 1 47 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Baltimore

18 (a) Funeral director Philip Herwig Sons

(b) Address 2024 Orleans St

19 (c) JUN 30 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1947 at AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2 1947 to June 28 1947 and that I last saw her alive on June 27 1947

Immediate cause of death Acute Coronary Occlusion — Duration 1 day

Due to Arteriosclerotic heart disease — Duration 4 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Israel Rosen M.D. M. D.

Address 2413 E. Monument St Signed

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C53017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

Registered No. C53017

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St & Linden Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2131 Cambridge St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Edward L. Wisniewski

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-3394

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Jennie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 21 Mar 1910

8. AGE: Years	Months	Days	If less than one day
37 37	3	8	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Stevedore

11. Industry or business

FATHER
12. Name Walter Wisniewski
13. Birthplace Poland

MOTHER
14. Maiden Name Felixa Bronzert
15. Birthplace Poland.

16 (a) Informant Jennie Wisniewski
(b) Address 2131 Cambridge St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 2-47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto Co.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern ave

19 (a) (b) (Huntington Williamsport Md.)

JUN 30 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 Jun 1947, at 3:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 27 Jun 1947, to 29 Jun 1947, and that I last saw him alive on 29 Jun 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to Rheumatic Heart Disease	2 yrs.
Due to	
Other Conditions Appendectomy & cholecystectomy. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation: Chronic cholecystitis & appendicitis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Allan Spies
Address Md. Gen. Hosp. Date signed 29 Jun 47

X

G53018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195c

G53018 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 - 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1919 Chase St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Galveston Ayres

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-15-10

8. AGE: Years 36 | Months 9 | Days 11 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Pompa Ayres

13. Birthplace Va.

MOTHER 14. Maiden Name Dampier ?

15. Birthplace Va

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof July 1, 1947 (month) (day) (year)

(c) Cemetery or crematory Buckingham, Va.

Location Virginia, Farmville

18 (a) Funeral director Mrs. Kate R. Williams

(b) Address 322 S. Main St.

19 JUN 30 1947 (b) (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 1947 at 10 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 4 1947 to June 26 1947 and that I last saw her alive on June 20 1947.

Immediate cause of death Pulmonary embolism — Duration 24 hrs.

Due to Cardiac hypertrophy and failure — Duration 6 mo's

Due to

Other Conditions Hypertension, Chronic pulmonitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene Lazarte M. D.

Address Johns Hopkins Hosp Date signed June 28 1947

G53019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195C

G53019 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) dea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 530 N. Pulmor St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME PARNELL GUNTHER

3 (b) If veteran, name war: World War II.
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife: —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1908

8. AGE: Years	Months	Days	If less than one day
39	3	27	hr. min.

9. Birthplace Winston-Salem, N. C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Thomas Gunther
13. Birthplace S. C.

MOTHER
14. Maiden Name Lula Young
15. Birthplace S. C.

16 (a) Informant Howard Foster
(b) Address 2130 N. Howard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-3-47 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Balto. Md.

18 (a) Funeral director Mrs Katie R. Williams
(b) 3327 N. Schroeder St

19 (a) JUN 30 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-27- 1947 at 5 40 P. M

21. I certify that I took charge of the remains described above, held an Autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute dilatation of heart
Acute edema of lungs
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 6/28/47

VS 151

G53020

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G53020 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1833 N. Chapel St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1833 N. Chapel St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel B. Webster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Emma J. Booth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 23, 1872

8. AGE: Years 75 | Months 4 | Days 4 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Paper-hanger (Retired)

11. Industry or business

FATHER 12. Name ~~Bill~~ John Webster

13. Birthplace Md. ~~Baltimore~~ Dillmyer

MOTHER 14. Maiden Name ~~Matilda Not Known~~

15. Birthplace Md.

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/30/47 (month) (day) (year)

(c) Cemetery or crematory Balto.

Location Balto. Md.

18 (a) Funeral director E. J. Fleming & Son

(b) Address 1938 E. Lafayette Ave.

19 (Date rec'd by registrar JUN 30 1947) Huntington Williams M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 20 Dec 1946, to 27 June 1947, and that I last saw h[illegible] alive on 26 June 1947.

Immediate cause of death	Duration
Cerebral hemorrhage	1 day
Due to Arteriosclerosis & hypertension	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Silverfine M.D.

Address 714 E. Preston Date signed 28 June

G53021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G53021

BHM-44640

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Year
(e) Length of stay in Baltimore (yrs., mos., or days) 12 Yrs.

2. USUAL RESIDENCE OF DEACEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2628 Flora Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Georgie Nelson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16-1911

8. AGE: Years	Months	Days	If less than one day
35	9	9	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Nelson
13. Birthplace Virginia

MOTHER
14. Maiden Name Louisa Green
15. Birthplace Virginia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 6/30/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Md.

18 (a) Funeral director Geo. H. Nelson
(b) Address 1303 Presstman St.

19 JUN 30 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH June 25 19 47, at 10:10M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 19 45, to June 25 19 47 and that I last saw her alive on June 25 19 47.

Immediate cause of death	Duration
Pulmonary Tuberculosis	9 yrs.
Due to	
Due to	
Other Conditions Tuberculous Enteritis (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. H. Nelson M. D.

Address Date signed 6-27-47

G53022

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G53022 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 721 S. Curley St.
(c) Hospital or institution: Res.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 19 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State M.D. (b) County Balto.
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 721 S. Curley St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Elizebeth M. Feehley

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-22-2440

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife James Howard Feehley

6 (c) If alive, give age 20 years

7. Birth date of deceased (mo., day, yr.) Jan. 8 1928

8. AGE:	Years	Months	Days	If less than one day
19	19	5	19	hrs. min.

9. Birthplace Balto. M.D. (Town, county, and state)

10. Usual Occupation Tailoring

11. Industry or business Tailoring

FATHER
12. Name William Woolshleger
13. Birthplace Balto. M. D.

MOTHER
14. Maiden Name Annetta Reina
15. Birthplace Italy

16 (a) Informant (Father) William Woolshleger
(b) Address 721 S. ~~Dee~~ Curley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 1 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. & Moravia Ave

18 (a) Funeral director Frank Della Vore
(b) Address 52 N. Morley Ave.

19 (a) JUN 30 1947 (Date received by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-27-1947 at 5 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 25 1947 to 6-27-1947. and that I last saw h[illegible] alive on 6-26 1947.

Immediate cause of death	Duration
Carcinoma of Descending Colon	3-15-47
Due to	
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.

Address 842 E. 41st Ave Date signed 6-28-47

G53023

CWK-110311

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13B

Registered No. G53023

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Month
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 805 Rutland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Bowler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Gertie (R. T.)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 18-1907

8. AGE: Years	Months	Days	If less than one day
39	10	7	hr. min.

9. Birthplace South Carolina
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Will Bowler
13. Birthplace South Carolina

MOTHER
14. Maiden Name Lizzie ?
15. Birthplace South Carolina

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof Jun-30-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore, Maryland

18 (a) Funeral director Mrs. Ida Bailey
(b) Address 1421 E. Jefferson St

19 JUN 30, 1947 (c) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH June 25 1947, at 4:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 30 1947, to June 25 1947 and that I last saw him alive on June 25 1947.

Immediate cause of death	Duration
Tuberculosis, Pulmonary, b/l far advanced	7 weeks
Due to Tuberculosis of Kidneys	P
Due to	
Other Conditions Phlebothrombosis, Pulmonary Embolism & Infarction (Include pregnancy within 3 months of death)	

Date of operation May 2, 1947
Major findings of operation: None
of autopsy: Pulmonary & Renal TBC.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Balt. City Hosp. Date signed 6-26-47

G53024

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 761

G53024
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Pikesville 8
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3501 Seven Mile Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Mr. Frank Mitchell Schofield

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Mrs. Bertha Schofield
alive 6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Sept. 5, 1873

8. AGE: Years	Months	Days	If less than one day
73	9	12 22	hr. min.

9. Birthplace Rhode Island
(Town, county, and state)
10. Usual Occupation Silversmith
11. Industry or business

FATHER
12. Name Allen Schofield
13. Birthplace England

MOTHER
14. Maiden Name Ann Bradley
15. Birthplace England

16 (a) Informant wife - Bertha M. Schofield
(b) Address 3501 Seven Mile Lane, Pikesville Md.

17 (a) burial (b) Date thereof 7/1/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) [illegible] 1947 (b) [illegible] Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1947, at 2 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 27 1947, to June 27 1947, and that I last saw h[illegible] alive on June 27 1947.

Immediate cause of death	Duration
arteriosclerotic heart disease	
Due to	
Due to	
Other Conditions Diabetes mellitus	at least 10 years

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman R. Freeman, M.D.
M. D.
Address Union Memorial Date signed June 27 47

937

G53025

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G53025

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1724 Darley Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK E. CLARK (Frank Edward Clark)

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 216-01-2741

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: Florence Clark

6 (c) If alive, give age: 30 years

7. Birth date of deceased (mo., day, yr.) 9/1/82

8. AGE: Years 64 | Months 9 | Days 27 | If less than one day ... hr. ... min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: Stock Clerk

11. Industry or business: U.S. Rubber Co.

FATHER
12. Name: Frank Hudson Clark
13. Birthplace: Maine

MOTHER
14. Maiden Name: Rosalett Wheeler
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. Florence Clark - widow
(b) Address: 1724 Darley Avenue

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 6/30/47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) 1947 (Date received by registrar) (b) ... Registrar

S-150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/27 1947, at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/22 1947 to 6/27 1947. and that I last saw h[illegible] alive on 6/27 1947.

Immediate cause of death: Cardiac failure

Due to: Coronary arterio-sclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: Coronary sclerosis. Old myocardial infarct

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John B. Wilson M. D.

Address St Joseph Hosp Date signed 6-27-47

G53026

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 48a

G53026 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1606 W Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leola Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: Negro

6 (a) (Single) married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-25-08

8. AGE: Years 39 | Months 3 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name William Jones.
13. Birthplace Glenlee, Howard Co., Md.

MOTHER
14. Maiden Name Carrie Giles
15. Birthplace Howard Co., Md.

16 (a) Informant Patient
(b) Address 1606 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-30-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
Address 1947 Schroeder St.

19 (a) JUN 30 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-27 1947 at 2:36 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-4 1947 to 6-27 1947 and that I last saw her alive on 6-27 1947

Immediate cause of death Intestinal obstruction — Duration

Due to Carcinoma - Metastases

Due to Carcinoma of Cervix

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
Means of injury

23. Signature Dr. L. B. Higgins Jr. M. D.
Address Provident Hosp. Date signed 6-30-47

G53027

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

Registered No. G53027

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 737 W. North avenue
(c) Hospital or institution: 14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) [redacted] yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 737 W. North ave.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
~~If yes, name country~~ Resident of USA 60 years

3 (a) FULL NAME GUSTAVE JOSEPH ERDMAN

3 (b) If veteran, name war

3 (c) Social Security Account No. 717-07-6104

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Katherine Keefer Erdman
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Mar. 31, 1873

8. AGE: Years	Months	Days	If less than one day
74	2	27	hr. ... min.

9. Birthplace Hanover, Germany (Town, county, and state)
10. Usual Occupation Civil Engineer
11. Industry or business

FATHER
12. Name Adolph Erdman
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace ~~Holland~~ Germany

16 (a) Informant Mrs. Katherine Erdman
(b) Address 737 W. North ave.

17 (a) Burial (b) Date thereof 7/1/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Evans Son Inc
(b) Address 118 W. Mt. Royal Ave
Huntington Williams, M.D.
Registrar

19 (a) Date received by (b) JUN 30 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1947, at 4.55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-21- 1947, to 6-27 1947, and that I last saw h~~im~~ alive on 6-26-1947.

Immediate cause of death Coronary Thrombosis — Duration 10 da

Due to

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chester Riland, M. D.
Address 2532 Edmondson Ave Date signed 6-28-47

X

G53028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G53028 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1626 E. 25th street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1626 E. 25th street
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME RUTH R. MILLER

3 (b) If veteran, name war: No

3 (c) Social Security Account No. none

4. Sex: Female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: George M. Miller

6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1905

8. AGE: Years	Months	Days	If less than one day
41	6	8	hr. min.

9. Birthplace: Millerstown, Pa. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: William Steffen
13. Birthplace: Millerstown, Pa.

MOTHER
14. Maiden Name: Clara Page
15. Birthplace: Millerstown, Pa.

16 (a) Informant: George M. Miller
(b) Address: 1626 E. 25th street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 1-47 (month) (day) (year)
(c) Cemetery or crematory: Mereland Memorial
Location: Taylor Ave.

18 (a) Funeral director: Chas. J. Evans Son Inc.
(b) Address: 118 W. Mt. Royal Ave.

19 (Registrar's signature) Huntington Williams, M.D. Registrar
JUN 30 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/26 1947, to 6/28 1947, and that I last saw h[illegible] alive on 6/28 1947.

Immediate cause of death: Coronary Thrombosis. — Duration: Sud[illegible]

Due to: embolism — 7 days

Due to: Femoral Thrombophlebitis

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Joseph Friedman, M. D.
Address 1206 E. Preston St. Date signed 6/30/47

VS 150

G53028

G53029

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G53029 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 829 E. Chase St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 829 E. Chase St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John J. Gilchrist

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 10, 1877

8. AGE: Years 69 | Months 10 | Days 18 | If less than one day: hr. min.

9. Birthplace Baltimore, Md (Town, county and state)

10. Usual Occupation Retired Druggist

11. Industry or business Washington D.C.

FATHER
12. Name Patrick Gilchrist
13. Birthplace Scotland

MOTHER
14. Maiden Name Margaret Finnerty
15. Birthplace Baltimore Md

16 (a) Informant Mrs Frances Boland
(b) Address 2917 Alameda Blvd

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof July 1, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Cathedral
Location 4300 Old Frederick Rd.

18 (a) Funeral director E. J. Conklin & Son
(b) Address 927 E. Lager St.

19 (a) (Date received by local registrar) (b) Huntington Williams M.D. Registrar

JUN 30 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1947 at 2:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 27 June 1947 to 28 June 1947, and that I last saw him alive on 27 June 1947.

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to Cardio-vascular disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Gilchrist M. D.
Address 714 E. Preston Date signed 30 June

G53030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 106 B

Registered No. G53030

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: Elmhurst
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr. 6M.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1908 Homewood Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Thomas Bond

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	212-16-0796A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Mary Alice Bond
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1869

8. AGE:	Years	Months	Days	If less than one day
	77	6	4	hr. min.

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation Scheer's Lumber Co.
11. Industry or business Retired

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Miss Alice Bond
(b) Address 1908 Homewood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/1/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 (a) JUN 30 1947 (Date rec'd by registrar) Tuttington Williams M.D. Registrar Address 4818 Reisterstown Rd

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1947, at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 11 1946, to June 28 1947, and that I last saw h[illegible] alive on June 28 1947.

Immediate cause of death	Duration
Cardiac Failure	1 day
Due to Bronchiectasis chronic severe, bilateral	7 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Manuel Levin M. D.
Date signed June 28/47

VS 150

G53031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 50

Registered No. G53031

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 South Fulton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 33 South Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME GRACE PORPORA

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FM	W	Married

6 (b) Name of husband or wife Joseph Porpora
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) 6/2/88

8. AGE: Years	Months	Days	If less than one day
59		27	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Samual Dalfanzo
13. Birthplace Italy

MOTHER
14. Maiden Name Anita Battaglia
15. Birthplace Italy

16 (a) Informant Samual Porpora
(b) Address 33 South Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/3/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 (a) JUN 30 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1947, at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/29 1947 to 6/29 1947 and that I last saw h[illegible] alive on 6/29 1947.

Immediate cause of death	Duration
Bronchopneumonia	3 days
Due to	
Due to	
Other Conditions Adenocarcinoma of breast (Include pregnancy within 3 months of death)	5 years

Date of operation June 1944
Major findings of operation: Carcinoma of breast
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify home, farm, or place)
(e) Means of injury

23. Signature Sheldon Wirk M.D.
Address 244 N. Hilton Date signed 6/29/47

VS 150

G53032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V133B

Registered No. G53032

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard & Linden
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2827 W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ethel P. Harrison

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-10-7786

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William A. Harrison

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Feb. 27, 1895

8. AGE: Years 52 | Months 4 | Days 2 | If less than one day ... hr. ... min.

9. Birthplace Mass. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Mr. Frederick Hill
13. Birthplace Maine

MOTHER
14. Maiden Name Mrs. Jane Perry
15. Birthplace England

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/2/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 (a) JUN 30 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-29 1947, at 8:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-16 1947 to 6-29 1947, and that I last saw h[illegible] alive on 6-29 1947.

Immediate cause of death Cardiac failure — Duration

Due to Post operation shock and hypostatic pneumonia

Due to Enlarged necrotic left kidney with Lemon Pus

Other Conditions and abscess formation

(Include pregnancy within 3 months of death)

Date of operation 6-27-47

Major findings of operation Enlarged necrotic left kidney

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Carlton Brailsford M. D.
Address Maryland General Hospital Date signed 6-29-47

VS 180

C 653033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G53033 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 954 Forrest St.
(c) Hospital or institution: Maryland Penitentiary
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ? Talbot
(c) City or town Easton (If outside city or town limits, write RURAL and give town)
(d) Street No. P.O. Box # 181 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Edward Bopper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26, 1926

8. AGE: Years	Months	Days	If less than one day
21	2	1	hr. min.

9. Birthplace Cordova, Md. (Town, county and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name James Bopper
13. Birthplace Cordova, Md.

MOTHER
14. Maiden Name Anna Gibson
15. Birthplace Cordova, Md.

16 (a) Informant Anna Bopper
(b) Address Easton Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 28/47 (month) (day) (year)
(c) Cemetery or crematory Richardson Cemetery
Location Easton, Md.

18 (a) Funeral director John D. Williams
(b) Address Easton Md

19 (a) 6/27/47 (Date rec'd by registrar) (b) [illegible]

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1947, 12 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 24 1947, to June 27 1947, and that I last saw him alive on June 27 1947.

Immediate cause of death	Duration
Dislocation of 5th cervical vertebra	
Due to Execution by hanging	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry W. D. Hollies, M. D.
Address Maryland Penitentiary Date signed 6-27-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G53034

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County BALTIMORE
(c) City or town CATONSVILLE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2202 ROCK HAVEN AVE (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Rose Thompson

3 (b) If veteran, name war: NONE

3 (c) Social Security Account No. NONE

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife JAMES EDWARD THOMPSON

6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) JULY 6, 1877

8. AGE: Years 69 | Months 11 | Days 23 | If less than one day ..... hr. ..... min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business

FATHER
12. Name JOHN H. PARRISH
13. Birthplace ENGLAND

MOTHER
14. Maiden Name REBECCA METCALF
15. Birthplace GERMANY

16 (a) Informant MRS VICTOR BUETEFISCH
(b) Address 2209 ROCK HAVEN AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JULY 1, 1947 (month) (day) (year)
(c) Cemetery or crematory MT. OLIVET
Location Frederick Ave Balto

18 (a) Funeral director Easton Bond
(b) Address Ellicott City, Md.

19 (a) JUN 30 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1947, at 6.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 28 1947 to June 25 1947, and that I last saw her alive on June 25, 1947.

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M.D.
Address University Hospital Date signed 6-27-47

G53035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G53035

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2028 Maisel St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2028 Maisel St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret M. Barnes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Edmund M. Barnes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1871

8. AGE: Years 76 | Months 4 | Days 18 | If less than one day ..... hr. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation H.W.

11. Industry or business

FATHER
12. Name George Wagner
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Smith
15. Birthplace Germany

16 (a) Informant Edmund M. Barnes
(b) Address 2028 Maisel St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 3/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Lutkie
(b) Address 410 E Edmondson Ave

19 (a) JUN 30 1941 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/29/47 19..., at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/8/47 19... to 6/27/47 19..., and that I last saw h e r alive on 6/27/47 19...

	Duration
Immediate cause of death Coronary Occlusion	
Due to Arteriosclerotic Cardio-vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Arthur Rosenheck M. D.

Address 2411 Washington Blvd Date signed 6/30/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G53036

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1804 Mc Henry St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1804 Mc Henry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Addison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	W.	Widow

6 (b) Name of husband or wife Late Edward T.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1862

8. AGE: Years	Months	Days	If less than one day
85	4	13	hr. min.

9. Birthplace Del.
(Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business

FATHER
12. Name Henry Bartscheller
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Edward R. Addison
(b) Address 527 S. Fulton Ave

17 (a) Burial (b) Date thereof July 2/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd

18 (a) Funeral director Harry H. Mitzel
(b) Address 4101 Edmondson Ave.

19 JUN 30 1947 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/29/47 19 at 9:15 M

21. I certify that death occurred on the date above stated, that I attended deceased from June 22 1947 to June 29 1947
and that I last saw him alive on June 26 1947

Immediate cause of death Hypertensive cardio-vascular disease

Due to Hypertension

Other Conditions Hemiplegia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Milton Siscovick M. D.
Address 14 29th St Date signed 6/30/47

G53037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G53037

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 900 Woodington Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 900 Woodington Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edgar E. Martin, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M.

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Gwendolyn nee O'Connor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1897

8. AGE: Years 49 | Months 8 | Days 19 | If less than one day ... hr. ... min.

9. Birthplace Penna.
(Town, county, and state)

10. Usual Occupation Insurance

11. Industry or business

FATHER
12. Name Benjamin Martin
13. Birthplace Penna

MOTHER
14. Maiden Name Harriet Frew
15. Birthplace Penna.

16 (a) Informant Mrs. Gwendolyn Martin
(b) Address 900 woodington Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 2/47. (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd.

18 (a) Funeral director Harry H. Ruhle
(b) Address 4101 Edmondson Ave.

19 JUN 30 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/28/47 19 ..., at ... M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan', 1938 to Jan 28 1947. and that I last saw him alive on 6-28- 1947.

Immediate cause of death Coronary Thrombosis — Duration 2 hrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. E. Wells M. D.
Address 4100 Edmondson Ave Date signed 6-28-47

C53038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 497

Registered No. C53038

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1258 Washington Blvd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1258 Washington Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha G. Hall.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	widow

6 (b) Name of husband or wife late John W.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 29, 1885

8. AGE: Years	Months	Days	If less than one day
61	7	29	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name John Peters
13. Birthplace Md

MOTHER
14. Maiden Name Ida Boyles
15. Birthplace Md

16 (a) Informant Miss Lillian Hall
(b) Address 1258 Washington Blvd

17 (a) Cremation (b) Date thereof 7-1-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd

18 (a) Funeral director Harry H. Wiltze
(b) Address 4101 E. Monument Ave.

19 (Date received) JUN 30 1947 (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/28/1947, at 1.40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/x/1947, to 6/28/1947 and that I last saw her alive on 6/24/1947.

Immediate cause of death	Duration
Congestive Heart Failure	2 days
Due to Metastatic Carcinoma	6 mos.
Due to Carcinoma-Uterus + Pain	1 yr
Other Conditions Malnutrition + Cachexia	4 mos.

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Chas Martin Jr.
Address 1433 W Balto St Date signed 6/28/47
M. D.

X

G53039

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G53039 Registered No.

CM 111447 ✓46 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE.
(c) Hospital or institution: Baltimore City Hospitals 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-4 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 730 E. Pratt ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cole, Lee

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Elizabeth (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4 - 1878

8. AGE: Years 68 | Months 11 | Days 15 | If less than one day ... hr. ... min.

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Robert Cole
13. Birthplace MD.

MOTHER
14. Maiden Name Elizabeth Cornelious
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) ... (b) Date thereof ...
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JUN 26 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JUN 30 1947 Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 - 1947, at 1.20P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 19 47 to June 19-1947, and that I last saw him alive on June 19 - 1947

Immediate cause of death: Carcinoma of Stomach — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurice M. Lacy, M. D.
M. D.
Address Baltimore City Hosp. Date signed 6-21-47

G53040

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 467

Registered No. G53040

NH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 4-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home Hope Mission
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Manning

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-12-3097

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1887

8. AGE: Years	Months	Days	If less than one day
59	7	6	hr. min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Manning
13. Birthplace New Jersey

MOTHER
14. Maiden Name Mary Fuche
15 Birthplace Pennsylvania

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School JUN 26 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUN 30 1947 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 1947, at 4.30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 19 47 to June 16 19 47, and that I last saw him alive on June 16 19 47

Immediate cause of death	Duration
Carcinoma of Rectum	
Due to	
Due to	
Other Conditions Carcinomatosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurice M. Lacy, M.D.
M. D.
Address Baltimore City Hosp Date signed 6-27-47

V S 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53041

BALTIMORE CITY HEALTH DEPARTMENT

BHB-81498 CERTIFICATE OF DEATH 159 Registered No. G53041

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave 16
(c) Hospital or institution West Balto Gen Hosp. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1641 N Bentalou Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Miller.
3 (b) If veteran, name war —
3 (c) Social Security Account No. —
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. —
6 (b) Name of husband or wife
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) 6/24/47
8. AGE: Years | Months | Days 8 | If less than one day ..... hr. ..... min.
9. Birthplace Balto Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Robert D Miller
13. Birthplace New Haven Conn.

MOTHER
14. Maiden Name Leah Finn
15. Birthplace Poland.

16 (a) Informant 1641 N Bentalou
(b) Address Balto Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof JUN 25 1947 (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JUN 25 1947 Commissioner of Health

18 (a) Funeral director
(b) Address

19 JUN 30 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1947 at 5:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-13 1947 to 6-24 1947 and that I last saw her alive on 6-21 1947

Immediate cause of death: Atelectasis — Duration
Due to Prematurity
Due to (Birth Wt 1½ lbs)
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Atelectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. J. Treptow M. D.
Address W. Balto Gen Hosp Date signed 6-24

X

G53042

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G53042

CM 111150 462

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 42 S. Fremont AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Williams, George

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Louise
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12 -1895

8. AGE: Years	Months	Days	If less than one day
51	8	8	hr. min.

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Thomas (D)
13. Birthplace Wales

MOTHER
14. Maiden Name Carrie Bolton (D)
15. Birthplace Ireland

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern AVE.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JUN 26 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JUN 24 1947 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 - 1947, at 2.25A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 - 1947, to June 20 - 1947, and that I last saw h im alive on June 20 -1947.

Immediate cause of death Lymphosarcoma of Stomach — Duration

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 6-6-47
Major findings of operation: Above

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marion M. Lacy, M.D.
M. D.
Address Baltimore City Hospitals Date signed 6-24-47

V S 150

G53043

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 567

G53043 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Washington
(c) City or town Hagerstown Nightfield
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOTTIE KIPE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife single

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sep 24, 1890

8. AGE: Years	Months	Days	If less than one day
56	9	6	hr. min.

9. Birthplace Strong Me (Town, county, and state)

10. Usual Occupation Telephone Operator

11. Industry or business

FATHER
12. Name John Kipe
13. Birthplace Sabillasville Md

MOTHER
14. Maiden Name Martha Musser
15. Birthplace Monrovia Md

16 (a) Informant Guy Kipe
(b) Address Blue Ridge

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 7 3 47 (month) (day) (year)

(c) Cemetery or crematory Bethel Md.
Location Bethel Cemetary

18 (a) Funeral director Wilby & Sroufe
(b) Address 2 [illegible] Hagerstown Md

19 (a) JUN 30 1947 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 JUNE 1947, at 12 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 13 June 1947, to 30 June 1947 and that I last saw h ER alive on 30 June 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Brain Tumor	
Due to	over
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R L Bauer M. D.
Address University Hosp Date signed 30 Jun 47

1 X

G53044

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH V 46 B

G53044
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2024 Christian St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-3
(e) Length of stay in Baltimore (yrs., mos., or days) 35yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2024 Christian St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Samuel Boxer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Late Annette
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years	Months	Days	If less than one day
80			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business None

FATHER
12. Name Simon BOzer
13. Birthplace Russia

MOTHER
14. Maiden Name RAY ?
15. Birthplace Russia

16 (a) Informant Charles Boxer
(b) Address 2024 Christian St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 1, 1947 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run Cem
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

JUL 1 1947 (Date rec'd by local registrar) (b) Huntington Williams, M.D.

VS 190

MEDICAL CERTIFICATION

10:45

20. DATE OF DEATH June 30 1947, at A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2 1947, to June 30 1947 and that I last saw [illegible] alive on 6/30 1947.

Immediate cause of death	Duration
[redacted] Carcinoma of stomach	6 mos.
Due to	
Due to	
Other Conditions Cerebral Thrombosis	24 hr.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [redacted] M.D.
Address 2030 Wilkens Ave Date signed 6/30/47

X

G53045

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

G53045 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 60 E. Heath Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 60 E. Heath Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Rice

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widowed

6 (b) Name of husband or wife William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20/1876

8. AGE: Years	Months	Days	If less than one day
70	II	9	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Henry Benyas
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Offenteg
15. Birthplace Germany

16 (a) Informant Mrs. Alberta Tilghman
(b) Address 60 E. Heath Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/I/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Baltimore, Md.

18 (a) Funeral director William Cook Inc.
(b) Address I2I7 St. Paul Street

JUN 30 1947 (Date rec'd by registrar) (c) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1947, at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1946 to 6/28 1947.
and that I last saw her alive on 6/28 1947.

Immediate cause of death	Duration
(a) Apoplexy	2 yrs
Due to (b) Arteriosclerosis	
Due to (c)	
Other Conditions Senile Senility	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address 1 S.E. Wash. Dr. Date signed 6/30/47 M.D.

G53046

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

G53046 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 W. Rogers Ave.
(c) Hospital or institution: Aged Home of M.E. Church 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 W. Rogers Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie W. Randel

3 (b) If veteran, name war	3 (c) Social Security Account No.
N	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1861

8. AGE: Years	Months	Days	If less than one day
86	3	25	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Andrew J. Randel
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Ann Chandler
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Marian O. Coates
(b) Address 2211 W. Rogers Ave.

17 (a) Burial (b) Date thereof 7/2/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore, Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul Street

JUN 30 1947
(Date rec'd by registrar)

(b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-29- 1947, at 2.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947, to June 29 1947, and that I last saw h.. alive on June 29 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	24 hrs.
Due to Arterio Sclerosis	20 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur J. Davies M. D.
Address 800 Cathedral St Date signed 6-30-47

X

G53047

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G53047
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Type correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address BELVEDERE AVE
(c) Hospital or institution: AGED HOME 27-17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO (If outside city or town limits, write RURAL and give town)
(d) Street No. GREENSPRING AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME TOBIAS BRODIE

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOW

6 (b) Name of husband or wife ETTA
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years	Months	Days	If less than one day
73			hr. min.

9. Birthplace RUSSIA (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name NOT KNOWN
13. Birthplace RUSSIA

MOTHER
14. Maiden Name BLUMA
15. Birthplace RUSSIA

16 (a) Informant MOSES BRODIE
(b) Address 4301 PIMLICO RD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7-1-47 (month) (day) (year)
(c) Cemetery or crematory BNAI ISRAEL
Location SOUTHERN AVE

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St.

JUL 1 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-30 1947 at 4:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-13 1947 to 6-30 1947 and that I last saw h[illegible] alive on 6-30 1947.

Immediate cause of death Chronic Cardio vascular disease
Due to Diabetes mellitus
Due to
Other Conditions

Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry V Vogel M. D.
Address Lewindale Home Date signed 6-30-47

G53048

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G53048

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2344 Waldo St. 7-3
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2344 Waldo St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna M. Painter

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Herman F. Painter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6 - 1893

8. AGE: Years	Months	Days	If less than one day
54	1	24	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Clipper
11. Industry or business Lanvale Pickle Factory

FATHER
12. Name Frank Bernard
13. Birthplace Austria

MOTHER
14. Maiden Name Mary Smith
15. Birthplace Austria

16 (a) Informant Herman F. Painter
(b) Address 2344 Waldo St.

17 (a) Burial (b) Date thereof July 2-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern Ave.

18 (a) Funeral director John A. Miller
(b) Address 2634 Jefferson St.

JUL 1 1947 (b) Huntington Williams, M.D.
(Date rec'd by Local Reg.) (Signature of Local Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1947, at 6A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 2 1947 to June 30 1947 and that I last saw her alive on June 28 1947.

Immediate cause of death	Duration
acute Cardiac Failure	1 day
Due to Generalized carcinomatosis	6 months
Other Conditions Primary site - unknown	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Isadore Rosen M. D.
Address 2438 E. Monument Date signed 6/30/47

G53049
AB- 110144

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH V13B

Registered No. G53049

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 16yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 Leadenhall St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Holley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frank

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2- 1904

8. AGE: Years 42 | Months 10 | Days 25 | If less than one day hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Hixie Evens or Hixie Evans
15. Birthplace N.C.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 9 47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore

18 (a) Funeral director Walter B. Sprigg
(b) Address 139 W. Lanvale St.

19 JUL 1 1947 (Date rec'd by local registrar) C. Hunnington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27- 1947, at 10.50 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-23- 1947, to 6-27 1947, and that I last saw her alive on 6-27 1947.

Immediate cause of death: Anasthetic - mitrous oxide, oxygen + ether.
Due to:
Due to: Pulmonary tuberculosis.
Other Conditions: Spontaneous pneumothorax.
(Include pregnancy within 3 months of death)
Date of operation 6/14/47 & 5/13/47
Major findings of operation: Pulmonary tuberculosis.
of autopsy: As above.

Duration: 1½ hr.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Hunnington Williams, M.D.
Address Baltimore City Hospitals Date signed 6/2 1947

G53050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √97

Registered No. G53050

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure that correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 419 N. BELNORD
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 419 N. BELNORD (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME JOSEPH MENGELE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: ELIZ. NIENDECKER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-14-1875

8. AGE: Years 72 | Months 3 | Days 16 | If less than one day ..... hr. ..... min.

9. Birthplace GERMANY (Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business ?

FATHER
12. Name JOHN MENGELE
13. Birthplace GERMANY

MOTHER
14. Maiden Name VERONICA FUCHSLAUER
15. Birthplace GERMANY

16 (a) Informant ELIZ. MENGELE - WIFE
(b) Address 419 N. BELNORD AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7-3-47 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. WOLFE ST

JUL 1 1947 (Date rec'd by registrar) Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 30, 1947, at 1:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-7-46 19..., to 6-30- 1947, and that I last saw h.. alive on 6-30- 1947.

	Duration
Immediate cause of death HEMORRHAGE (GASTRO-INTESTINAL)	1 DAY
Due to OESOPHAGEAL VARICES	1 YEAR
Due to HYPERTENSION AND ARTERIOSCLEROSIS	10 YEARS
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? (Specify type of place)
(e) Means of injury

23. Signature Benj. B. Wiener, M.D. M. D.
Address 448 N. Luzerne Ave Date signed 7-7-47

G53051

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1947

G53051
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) – 14

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County –
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1730 Mc Culloh (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert Wise

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Mary M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25, 1893

8. AGE: Years 53 | Months – | Days 8 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business Night club

FATHER
12. Name Obie Wise
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Agnes Queen
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Mary M. Wise
(b) Address 1738 Mc Culloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 1, 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Balto Co. Md.

18 (a) Funeral director Leo F. Holland
(b) Address 1631 Druid Hill Ave.

JUL 1 1947 (a) (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27, 1947 at 4 21 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 27 1947 to June 27 1947, and that I last saw him alive on June 26 1947

Immediate cause of death Respiratory
Due to cardiac failure
Due to (Cardiovascular Hypertensive disease)
Other Conditions Cerebral hemorrhage accident
(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....
of autopsy: .....

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature A. Mitchell M. D.
Address Md Gen Hosp Date signed 6/27/47

G53052

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G53052

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 9 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 423 N. Paca st. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John Caldwell

3 (b) If veteran, name war: World 2.

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Margaret Caldwell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
46 47			hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: Clerk

11. Industry or business

FATHER — 12. Name: Wm F. Caldwell
13. Birthplace: Balto

MOTHER — 14. Maiden Name: Ida M. Crawford
15. Birthplace: Balto

16 (a) Informant: Wm F. Caldwell
(b) Address: 2037 Mura St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 2. (month) (day) (year)
(c) Cemetery or crematory: Balto National
Location: Rural

18 (a) Funeral director: Ulrich Funeral Home
(b) Address: 2008 Orleans St

19 JUL 1 1947 Huntington Williams M.D. Registrar
(Date rec'd by Local Reg.)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 19 47, at 11:40 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Lobar pneumonia

Due to:

Other Conditions: Fat infiltration of liver, Myocardial degeneration
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: George L. Merrill M.D. Medical Examiner.
Date signed 6/30/47

G53053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G53053 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 18 E Eager st
(c) Hospital or institution: 26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 12yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 69 Fourth ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grover Cleveland Allison

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	Divorced

6 (b) Name of husband or wife Geraldine Rogers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 10 1867

8. AGE: Years	Months	Days	If less than one day
60	2	18	hr. min.

9. Birthplace Pennsylvania
(Town, county, and state)
10. Usual Occupation Safety engineer
11. Industry or business

FATHER
12. Name Wesley G Allison
13. Birthplace Pa

MOTHER
14. Maiden Name Mary Reagen
15. Birthplace Pa

16 (a) Informant Mrs Robt W Brown
(b) Address North Boston N Y

17 (a) Removal (b) Date thereof July 2 -
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Patchin N Y
Location Patchin pl

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Eutaw

JUL 1 1947 (a) Huntington Williams M D
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 28 1947, at 1:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 19 , to JUNE 28 1947, and that I last saw h[illegible] alive on JUNE 28 1947.

Immediate cause of death Essential Hypertension
Coronary Thrombosis

Duration
5 Years 4 Months 1 Day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ralph G Hills M. D.
Address 18 E Eager st Balto Date signed June 28 1947

X

G53054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V48B

Registered No. G53054

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2721 Guilford Ave.
(c) Hospital or institution: 12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 2721 Guilford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura A. Guilford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Horace H. Guilford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24, 1858

8. AGE:	Years	Months	Days	If less than one day
	88	8	4	hr. min.

9. Birthplace Ohio (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Wm. H. Stitt
13. Birthplace Ohio

MOTHER
14. Maiden Name Eliz. G. Hickman
15. Birthplace Ohio

16 (a) Informant Ellis K. Guilford
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 1, 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Fred. Ave. Balto. Md.

18 (a) Funeral director John D. Mitchell & Sons Inc.
(b) Address 1900 Eutaw Place

19 (a) JUL 1 1947 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1945 to 6/28 1947 and that I last saw her alive on 6/27 1947

Immediate cause of death Carcinomatosis — Duration 3 yrs.

Due to

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address 2020 N. Charles St. Date signed 6/30/47

X

G53055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

G53055 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2520 Greenmount Ave.
(c) Hospital or institution: Southern Hos. & Home 20-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 507 N. Monroe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dara Howard

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Joseph W. Howard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1870

8. AGE: Years	Months	Days	If less than one day
76	11	24	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Ballard Byran
13. Birthplace Md.

MOTHER
14. Maiden Name Anna Tolson
15. Birthplace Md.

16 (a) Informant Records of Southern Hos. & Home
(b) Address 2520 Greenmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 2, 1947 (month) (day) (year)
(c) Cemetery or crematory Chester
Location Chestertown, Md.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place

JUL 1 1947 (Date rec'd by Registrar) (Huntington Williams, M.D. Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1947, to June 29 1947, and that I last saw her alive on June 28 1947.

Immediate cause of death — Duration

Due to Chronic Interstitial Nefritis

Due to

Other Conditions Age.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. Kurt C. Blake M. D.
Address Med. Arts Bldg. Date signed

X

G53056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G53056

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 533 Cumberland Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Storey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1901

8. AGE: Years 45 | Months 11 | Days 8 21 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Edward Wilson
13. Birthplace Md.

MOTHER
14. Maiden Name Ida Cooper
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. William Storey
(b) Address 533 Cumberland St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-2-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) Date rec'd by Reg. JUL 1 1947 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27, 1947 at 4 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 ... to June 27, 1947. and that I last saw h C. alive on June 27, 1947.

Immediate cause of death Cardio-Resp Failure — Duration

Due to Hodgkin's - Possible Multiple Myeloma or Leukemia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Evangeline R. Jennings M.D.
Address Univ. Hosp. Date signed 6/28

G53057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G53057

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Harlem Lodge
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence A. Mann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 8 1892

8. AGE: Years 54 | Months 9 | Days 20 19 | If less than one day hr. min.

9. Birthplace [illegible] Penn.
(Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business Attendant

FATHER
12. Name [illegible]
13. Birthplace Unknown

MOTHER
14. Maiden Name Ann O'Mahoney
15. Birthplace Unknown

16 (a) Informant Roger Dunn Dry
(b) Address Catonsville Md

17 (a) Burial (b) Date thereof 7-3-47
(Burial, cremation, or removal) (month) (day) (year)

Cemetery (Name) Dulaney Valley Gardens
Location Govans Md

18 (a) Funeral director Geo. A. Farley
(b) Address Catonsville Md

JUL 1 1947 (b)
(Date rec'd by Registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28, 1947 at 12:10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute generalized peritonitis

Due to perforated gastric ulcer

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner.
Date signed 6/28/47

C53058 Newby

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

171a

C53058
Registered No. (1947)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 25
(c) Hospital or institution: South Dallas General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37 min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Cherry Hill (If outside city or town limits, write RURAL and give town)
(d) Street No. 309 Seagull Ave (or location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James T. Newby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	married

6 (b) Name of husband or wife Jeannine Newby

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace Suffolk, Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Jimmy Newby
13. Birthplace Va.

MOTHER
14. Maiden Name Mamenia Newby
15. Birthplace Va.

16 (a) Informant Diane Newby
(b) Address 309 Seagull Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/4/47 (month) (day) (year)
(c) Cemetery or crematory
Location Suffolk Va.

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Brantley Ave

JUL 1 1947 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-29-1947, at 11 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry (Autopsy, Inspection or Inquiry) found that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture of Skull & intracranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-29-47 at 937 P. M.
(b) Where did injury occur? Hanover & Reedbird Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedes. Struck by Car

23. Signature Edward L Kenny Medical Examiner M.D.
Date signed 6-30-47

X

C53059

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 467

Registered No. C53059

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 371 S. Woodyear St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 yrs 3
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 371 S. Woodyear St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lucy Florence Mooney

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Michael J. Mooney

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 2, 1867

8. AGE: Years 79 | Months 10 | Days 27 | If less than one day hr. min.

9. Birthplace Indiana (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John W. Howell
13. Birthplace Indiana

MOTHER
14. Maiden Name Elvira Black
15. Birthplace Indiana

16 (a) Informant Joseph P. Mooney
(b) Address 371 S. Woodyear St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 2, 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director H. C. & B. M. Walter
(b) Address Pratt & Stricker

19 JUL 1 1947 Huntington Williams M.D. (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1947, at 3:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1945 to June 29 1947, and that I last saw her alive on June 29 1947

Immediate cause of death: Cancer of Rectum — Duration 2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert H. Hart M.D.
Address 2020 Wilkens Ave Date signed 6/30/47

G53060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

Registered No. G53060

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp. 15-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 12
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3401 Park Heights Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS MAGGIO

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Maria S. Maggio
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1888

8. AGE: Years	Months	Days	If less than one day
58	11	15	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Barber
11. Industry or business Self

FATHER
12. Name Phillip Maggio
13. Birthplace Italy

MOTHER
14. Maiden Name Catherine Guerico
15. Birthplace Italy

16 (a) Informant Mrs. Maria S. Maggio
(b) Address 3401 Park Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/3/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 Filed JUL 1 1947 Huntington Williams, M.D.
(Date received by registrar)

V$ 1150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-30 1947, at 4 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-25 1947 to 6-30 1947, and that I last saw him alive on 6-30 1947.

Immediate cause of death PNEUMONIA, BRONCHO

Due to POST-OPERATIVE

Due to

Other Conditions METASTATIC CARCINOMA OF RT. KIDNEY
(Include pregnancy within 3 months of death)

Date of operation 6-28-47

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Lerman M. D.
Address Sinai Hosp. Date signed 6-30-47

G53061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

Registered No. G53061

CM. 111635

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE.
(c) Hospital or institution: Baltimore City Hospitals. 19-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Meryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1420 N. Fayette ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Reynolds, Louis Joseph

3 (b) If veteran, name war: none
3 (c) Social Security Account No. 214-12-1162

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April -29 -1910

8. AGE: Years 37 | Months 2 | Days 1 | If less than one day ... hr. ... min.

9. Birthplace Baltimore MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Calvert Metal Mfg. Co.

FATHER
12. Name James Reynolds
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary E. Tarrent
15. Birthplace MD. (Balto.)

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern AVE

17 (a) Burial (b) Date thereof 7/3/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUL 1 1947 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 - 19 47, at 6.50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 23 1947, to June 30 -19 47, and that I last saw him alive on June 30 19 47.

Immediate cause of death	Duration
Pulmonary Tuberculosis	3 yrs
Due to	
Due to	
Other Conditions aortic aneurysm due to syphilis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H.E. Wright M. D.
Address Balt City Hosp Date signed 6/30/47

1312

G53062

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 93E

Registered No. G53062

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 403 E. Lafayette Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 - 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 403 E. Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MICHAEL G. KILCHENSTEIN

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	216-14-3451

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Katherine E. Kilchenstein (nee Hahn) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1862

8. AGE: Years	Months	Days	If less than one day
84	11	23	hr. min.

9. Birthplace Baltimore Co., Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Kilchenstein
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden Name Mary Fisher
15 Birthplace Balto. Co., Md.

16 (a) Informant Mrs. Katherine E. Kilchenstein
(b) Address 403 E. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/2/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

JUL 1 1947 (Date rec'd) [illegible] Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29, 1947 at 2:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1946 to 6/25 1947; that I last saw him alive on 6/25 1947.

Immediate cause of death Myocardial failure — Duration years

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. T. Buttenheim M.D.
Address 5829 Belair Rd Date signed 6/30/47

G53063

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G53063 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2135 W. Baltimore St.
(c) Hospital or institution:
20
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2135 W. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLARA MOHR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Charles H. Mohr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 20, 1862

8. AGE: Years	Months	Days	If less than one day
85	4	9	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name August Steinwedel
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Gasdorf
15 Birthplace Germany

16 (a) Informant Miss Helen C. Mohr
(b) Address 2135 W. Baltimore St.

17 (a) Burial (b) Date thereof 7/3/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 JUL 1 1947 Huntington Williams MD
(Date rec'd by registrar) (Registrar)

V 5 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29, 1947, at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1947 to June 29 1947 and that I last saw h-e alive on June 29 1947.

Immediate cause of death — Duration

Bronchopneumonia — 1 day

Due to Arteriosclerosis

Due to Hypertension

Other Conditions Parkinsonian state

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas. A. Parker M.D.

Address 2145 W. Balto St. Date signed 6/30/47

C53064

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registration No. C53064

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1529 W. Fairmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
Street No. 1529 W. Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Alexander.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: C

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Daniel Alexander

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept. 1903

8. AGE: Years: 43 | Months: 9 | Days | If less than one day: hr. min.

9. Birthplace: Mecklenburg Co., Va.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Robert Jones.
13. Birthplace: Va.

MOTHER
14. Maiden Name: Hannie Thipen.
15. Birthplace: Va.

16 (a) Informant: Daniel Alexander.
(b) Address: 1529 W. Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 7-1-1947 (month) (day) (year)
(c) Cemetery or crematory: Mt. Zion.
Location:

18 (a) Funeral director: Mrs Fatty R. Williams
(b) Address: 322 N. Schroeder St

Date rec'd by Local Registrar: 1947 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6/26/47 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1947 to 6/26/47, and that I last saw h[illegible] alive on 6/23/47.

	Duration
Immediate cause of death: Myocardiate	Years
Due to: Enteritis	Months
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Walter J Moore M.D.
Address: 202 Edmondson Date signed: 7/1/47

X

G53065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G53065

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Mount
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 71 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 27 N. Mount St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-18-2440a

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	C	M.

6 (b) Name of husband or wife Della Dellas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2 1875

8. AGE: Years	Months	Days	If less than one day
71	9	28	hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Alfred Johnson
13. Birthplace N. C.

MOTHER
14. Maiden Name Alice Johnson
15 Birthplace N. C.

16 (a) Informant Della D. Johnson
(b) Address 27 N. Mount St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 7-3-47 (month) (day) (year)
(c) Cemetery or crematory Pleasant Hill
Location Vanceboro N. C.

18 (a) Funeral director Samuel W. Sullivan Sr.
(b) Address 1011 W. Baltimore St.

19 (a) (Date received) (Registrar) for Williams M.D.

JUL 1 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1947, at 12:20 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-26 1947, to 6-30 1947, and that I last saw him alive on 6-29 1947

Immediate cause of death Cerebral Hemorrhage 4 days

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. D. Loyless
Address 27 N. Mt. St. Date signed 6-30-47

VS 150

G53066

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13/a

Registered No. G53066

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Caton & Wilkens Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 2 days
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED: 29
(a) State: Md. (b) County: Baltimore
(c) City or town: Baltimore - 29
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 803 Braeside Rd.
(If rural give location)
(e) Citizen of foreign country?: no (Yes or No)
If yes, name country:

3 (a) FULL NAME: Julia Ahern — Julia Catherine Ahern

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Alfred Ahern

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 19, 1888

8. AGE: Years: 59 | Months: 4 | Days: 11 | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER
12. Name: John Deany
13. Birthplace: (Maryland) Ireland

MOTHER
14. Maiden Name: Julia
15. Birthplace: (Maryland) Ireland

16 (a) Informant: Alfred J. Ahern
(b) Address: 803 Braeside Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: July 3 1947 (month) (day) (year)
(c) Cemetery or crematory: Mem. Cathedral
Location: Old Frederick Rd

18 (a) Funeral director: Harry H Weyler
(b) Address: 410 Edmondson Ave

19 JUL 1 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 30 1947, at 10:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 25 1947 to June 30 1947, and that I last saw h[illegible] alive on June 30 1947.

Immediate cause of death: Cardiac failure
Myocardial infarction - pneumonia
Due to: Pleuro thrombosis - Benign nephrosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?: (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?: (Specify type of place) While at work?:
(e) Means of injury:

23. Signature: [illegible] MD

Address: [illegible] Date signed: 6/30/47

G53067 CM

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1213

G53067 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE.
(c) Hospital or institution: Baltimore City Hospitals 27-14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 45 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 909 N. University Parkway Z 10
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Holmes Matilda — Matilda Holmes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? - ? - ?

8. AGE: Years	Months	Days	If less than one day
70 ?			hr. min.

9. Birthplace Ervington VA.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Selden Holmes (D)
13. Birthplace VA.

MOTHER
14. Maiden Name Matrib ?
15. Birthplace VA.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-9-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William J Jackson
(b) Address 916 Pennsylvania ave

(Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 - 1947 at 10.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 17 1946 to June 27 1947 and that I last saw her alive on June 27 1947

Immediate cause of death	Duration
(a) Pericarditis, failure	
Due to (b) Tuberculosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Tbc

of autopsy: tuberculosis - salvarsan

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H Vinson M.D M.D.
Address Balto City Hosp Date signed July 47

G53068

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G53068 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dept.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1125 Pennsylvania Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY EVELYN Thornton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Spencer

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2-22- 1845

8. AGE: Years	Months	Days	If less than one day
52	4	7	hr. min.

9. Birthplace Enfield N. C. (Town, county, and state).

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Kenney Coffield
13. Birthplace N. C

MOTHER
14. Maiden Name Susie Brinston
15. Birthplace N. C.

16 (a) Informant Spencer Thornton
(b) Address 1125 Penna ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 7-3-47 (month) (day) (year)
(c) Cemetery or crematory Enfield Cem.
Location Enfield, North Carolina

18 (a) Funeral director Gilliam & Jackson
(b) Address 916 Pennsylvania Ave, Washington, D.C.

19 (a) JUL 1 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/29 1947, at 10:4 M

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

Signature C. P. Smelnick M.D.
Medical Examiner.
Date signed 6/30/47

VS 151

PRINT WITH PENCIL, WRITE UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53069

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G53069

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Ln.
(c) Hospital or institution: Home for the Aged Room
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 -
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry McC Cambridge

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	W.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1861

8. AGE: Years	Months	Days	If less than one day
85 86	11	20	hr. min.

9. Birthplace Scotland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Harry McC Cambridge
13. Birthplace

MOTHER
14. Maiden Name Ellen McC Mahon
15. Birthplace

16 (a) Informant Wife Lives 2 The Door
(b) Address 1200 Valley Ln.

17 (a) Burial (b) Date thereof July 3, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore

18 (a) Funeral director Rita Wendell
(b) Address 900 East Biddle St

19 (a) [illegible] (b) Huntington Williams, M.D.
JUL 1 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1947, at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947, to June 30 1947, and that I last saw him alive on June 30 1947.

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Chronic myocarditis	2 yr
Due to	
Other Conditions Arter Sclerosis	10 yr

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E North Av Date signed 7/1/47

X

G53070 CHK-111751

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G53070 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 13-8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. ~~3621~~ 3621 Sweet Air Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel A. Sullivan

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ella Sullivan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2-1870

8. AGE: Years	Months	Days	If less than one day
77	3	28	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Farming (Retired)
11. Industry or business

FATHER
12. Name Jesse Sullivan
13. Birthplace Maryland

MOTHER
14. Maiden Name Amelia Brown
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 3-1947 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Co. Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) [illegible] (b) Remington-Hillsmere Md. Registrar

JUL 1 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 19 47, at 2:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 27 19 47 to June 30 19 47, and that I last saw h im alive on June 30 19 47.

Immediate cause of death	Duration
Bronchopneumonia	2 days
Due to	
Due to	
Other Conditions Arteriosclerosis + Hypertensive Cardiovascular Disease	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm R. Scarborough M. D.
Address Balto. City Hosp. Date signed 6-30-47

X

G53071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G53071

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1411 E. Clement St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Earl Abrahamsen

3 (b) If veteran, name war	3 (c) Social Security Account No.
WW I	218-22-9108

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Eloise Gay Abrahamsen
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Apr. 14, 1887

8. AGE: Years	Months	Days	If less than one day
60	2	15	hr. min.

9. Birthplace Norway (Town, county, and state)
10. Usual Occupation Retired Coast Guardsman
11. Industry or business

FATHER
12. Name John Abrahamsen
13. Birthplace Norway

MOTHER
14. Maiden Name Nicoline Svenson
15. Birthplace Norway

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/2/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore National Cem.
Location Frederick Ave.
18 (a) Funeral director Charles F. Hill
(b) Address 1521 E. Fortlee
19 (a) Filed 7/1 1947 (b) Huntington Williams, M.D.
(Date rec'd by reg.) Address

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1947, at 11:23 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 1947 to June 29 1947 and that I last saw h im alive on June 29 1947.

Immediate cause of death	Duration
Nephrosclerosis, chronic, severe, with myocardial hypertrophy and hypertension.	Unknown
Due to: (2) Endocarditis, aortic and mitral with moderate aortic	Unknown
Due to: stenosis, probably rheumatic	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 6/30/47

VS 150

X

G53072

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G53072

170c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 0 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Pasadena
(If outside city or town limits, write RURAL and give town)
(d) Street No. Greenhaven Road
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Gustaves F. Johnson (August)

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-6109

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mary H. Johnson

(c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) January 6, 1884

8. AGE: Years 63 | Months 6 5 | Days 23 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Ironworker

11. Industry or business Md. Drydock Co

FATHER
12. Name Winfield Johnson
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Maria Stafford
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Mary H. Johnson (wife)
(b) Address Green Haven, Pasadena Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 3 1947 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Anne Arundel Co, Md.

18 (a) Funeral director A. Howard Evans
(b) Address 1400 S. Charles St., Balto. 30, Md.

19 (a) Date rec'd by Registrar JUL 1 1947 (b) Registrar Hollingsworth Miller

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-29-1947, at 1:25 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemorrhage due to punctured lung; Fractured pelvis; Compound Comminuted fractures of leg bones; Subarachnoid Other hemorrhage, base of skull.
(Include pregnancy within 3 months of death)

22. If external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6/29/47 at 10 a.m. p.m.
(b) Where did injury occur? Sunset Beach, Stoney Creek Rd
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedes struck by auto.

23. Signature Howard J. Mancini M.D.
Medical Examiner.
Date signed 6-30-47

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G53072

53073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B

Registered No. G53073

WH 111289

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 57 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1504 Marshall St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Bessie Huber~~ Elizabeth Dean Huber (Bessie Huber-Hudak)

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: William H. Huber (Deceased)

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 8, 1885

8. AGE: Years 62 | Months — | Days 21 | If less than one day ____ hr. ____ min.

9. Birthplace New York, Elmira
(Town, county, and state)

10. Usual Occupation Waitress

11. Industry or business Dunn Restraurant

FATHER
12. Name ~~Hebb~~ Bailey
13. Birthplace ~~Pa.~~ N.Y.

MOTHER
14. Maiden Name ~~Alice~~ Taylor
15. Birthplace ~~Va.~~ Balto., Md.

16 (a) Informant Records at Baltimore City Hospitals
(b) Address 4940 Eastern Ave. Mrs. Fred C. Dunn

17 (a) Burial — (b) Date thereof 1507-Bert. 47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cedar Hill - July 3, 1924
Location A. G. Co., Md.

18 (a) Funeral director A. Hayward Evans
(b) Address 1400 St. Charles St. Balto 39, Md.

19 (a) ____ (b) ____

Registrar

JUL 1 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 19 47 at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 9 1947, to June 29 19 47, and that I last saw her alive on June 29 19 47

Immediate cause of death: Carcinoma of stomach with metastases to liver — Duration

Due to: ____

Due to: Pulmonary edema, Arteriosclerotic heart disease, Generalized arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation ____

Major findings of operation: ____

of autopsy: at chance

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____
(Specify type of place)
(e) Means of injury ____

23. Signature R. A. Gibbon M. D.

Address Baltimore City Hospitals Date signed 6/30/47

C53074

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. C53074

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor & Lakeland
(c) Hospital or institution: West Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1939 Herbert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Julia Monroe Rodwell

3 (b) If veteran, name war: *****

3 (c) Social Security Account No. ------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife: Harry E. Monroe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6, 1888

8. AGE: Years	Months	Days	If less than one day
59	0	24	hr. min.

9. Birthplace: Warrington, N. Carolina (Town, county, and state)
10. Usual Occupation: House-Work.
11. Industry or business: At home.

FATHER
12. Name: James R. Rodwell
13. Birthplace: North Carolina

MOTHER
14. Maiden Name: Pattie Ray Gardner
15. Birthplace: North Carolina

16 (a) Informant: Charles J. (Creelmore) (Rodwell) Son
(b) Address: 1939 Herbert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7- 2- 47. (month) (day) (year)
(c) Cemetery or crematory: Riverside Cemetery
Location: Norfolk, Va.

18 (a) Funeral director: Charles L. Zeiler
(b) Address: 3605 Fait Ave.

19 (d) JUL 1 1947 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 June 19 47 at 1:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 27 April 19 47 to 30 June 19 47, and that I last saw her alive on 30 June 19 47

Immediate cause of death	Duration
Septicemia	
Due to: Bilateral Bronchopneumonia, Multiple Decubitus Ulcers	
Due to:	
Other Conditions: Patent Auricular Septal Defect	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Lester A. Straub Jr. M. D.
Address: West Baltimore Gen. Hosp. Date signed 6/30/47

G53075

BALTIMORE CITY HEALTH DEPARTMENT X ✓ Registered No. G53075

CERTIFICATE OF DEATH 52B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & N
(c) Hospital or institution Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Edgewood (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Ward

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 29 1881

8. AGE: Years 65 66 | Months 7 | Days - | If less than one day ....hr. ....min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Peter Ward

13. Birthplace Ohio

MOTHER 14. Maiden Name Mary ?

15. Birthplace Ohio

16 (a) Informant David N. Woolford

(b) Address 1724 Thames St

17 (a) Burial (b) Date thereof July 2 1947 (month) (day) (year)
(Burial, cremation, or removal)

(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director John A Myers

(b) Address 3600 E Baltimore St

19 JUL 1 1947 Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27 1947, at 5:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 17 1947 to June 27 1947, and that I last saw h[illegible] alive on June 28 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to Generalized Arteriosclerosis	
Due to Adenoma of Bladder	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation July 1947

Major findings of operation: Adenoma of Bladder

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Hyde M.D.
Address Sinai Hospital Date signed 6/29/47

G53076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G53076

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2101 W. Cold Spring Lane.

(c) Hospital or institution: Cold Spring Convalescent Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2101 W. Cold Spring La. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Kipp

3 (b) If veteran, name war: —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. ?

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1868

8. AGE: Years 79 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER — 12. Name ? — 13. Birthplace ?

MOTHER — 14. Maiden Name ? — 15. Birthplace ?

16 (a) Informant Records - Convalescent Home

(b) Address 2101 W. Cold Spring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-2-47 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location City

18 (a) Funeral director Wiedefeld & Son

(b) Address Greenmount Ave & 22nd St.

19 (a) Filed July 1 1947 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-30-47 19 , at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/1 1946, to 6/30 1947, and that I last saw h[illegible] alive on 6-29 1947.

	Duration
Immediate cause of death: Broncho Pneumonia.	7 days
Due to: Myocarditis - Chronic	10 yrs.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Norman R Kleiman M. D.

Address 3803 Edmondson Ave Date signed 6/30/47

VS · 150

G53077

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

G53077
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12 1
(c) Hospital or Institution: St Joseph's Hospital DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and name town)
(d) Street No. 4102 Underwood Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thor E. Ness

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Suzanne Visser

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 10/2/18 42

8. AGE: Years 24 yrs 8 | Months 8 | Days 7 | If less than one day ..... hr. ..... min.

9. Birthplace Oslo, Norway (Town, county, and state)

10. Usual Occupation Ship Chandler - 1st Comm.

11. Industry or business U.S. Naval Reserve

FATHER
12. Name Bejona Ness
13. Birthplace Norway

MOTHER
14. Maiden Name Unobtainable
15. Birthplace Norway

16 (a) Informant Mrs. Suzanne Ness
(b) Address 4102 Underwood Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/2/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore, Md.

18 (a) Funeral director H. W. Meeks and Son
(b) Address 805 N. Calvert Street

19 (a) JUL 1 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1947, at 6 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Reynolds M.D. Medical Examiner
Date signed June 29, 1947

correct age is especially important. Physicians: please write

G53078

BALTIMORE CITY HEALTH DEPARTMENT

BC# D82388 CERTIFICATE OF DEATH 159

Registered No. G53078

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave
(c) Hospital or institution: West Balto Gen Hosp. 13-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 6 hrs

2. USUAL RESIDENCE OF DECEASED: 17
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2920 Parkwood Ave
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Shapiro

3 (b) If veteran, name war — 3 (c) Social Security Account No. #

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/28/47

8. AGE: Years	Months	Days	If less than one day
			6 hr. 9 min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation infant
11. Industry or business

FATHER
12. Name Sidney Shapiro
13. Birthplace Baltimore

MOTHER
14. Maiden Name Freda Lebowitz
15. Birthplace Baltimore

16 (a) Informant
(b) Address 2920 Parkwood Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JUN 30 1947
18 (a) Funeral director Commissioner of Health
(b) Address
19 JUL 1 1947 (b)
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1947 at 8:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/28/47 19 to 6/28/47 19, and that I last saw h[illegible] alive on 6/28/47 19

Immediate cause of death ~~[illegible]~~ respiratory failure — Duration
Due to prematurity
Due to
Other Conditions Hydramnios
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. S. Shapiro M.D.
Address WBG Hospital Date signed 6/28/47

G53079

BALTIMORE CITY HEALTH DEPARTMENT X

BC# 382532 CERTIFICATE OF DEATH 159

✓ G53079 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette and Calhoun Sts.
(c) Hospital or institution:
Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 hr.

2. USUAL RESIDENCE OF DECEASED: Carroll
(a) State Md. (b) County Westminster, Md.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Fayette and Calhoun Sts.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No.

3 (a) FULL NAME Baby Boy Little

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Infant

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 28 June 1947

8. AGE: Years	Months	Days	If less than one day
			1 hr. — min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business —

FATHER 12. Name Richard Elting Little
13. Birthplace Westminster, Md.
MOTHER 14. Maiden Name Betty Jane Cashman
15. Birthplace Taneytown, Md.

16 (a) Informant Richard Elting Little
(b) Address A-204 Woodside Road

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JUN 30 1947
18 (a) Funeral director Commissioner of Health
(b) Address
JUL 1 1947 (Date rec'd by registrar) (Huntington Williams, M.D.)

MEDICAL CERTIFICATION O.S.T.

20. DATE OF DEATH 6/28 1947, at 9:45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/28 1947, to 6/28 1947, and that I last saw h[illegible] alive on 6/28 1947.

Immediate cause of death Cerebral anoxia — Duration
Due to Prematurity
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. M. Baumgardner M. D.
Address Balto 6 - Md. Date signed

VS 150

X

G53080

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

B(# 82387 159

G53080 ✓ Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Payne Ave 16
(c) Hospital or institution: West Balto Gen Hosp 13-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) hrs
(e) Length of stay in Baltimore (yrs., mos., or days) hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2920 Parkwood Ave (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Shapiro

3 (b) If veteran, name war — 3 (c) Social Security Account No. F

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/28/47

8. AGE: Years | Months | Days | If less than one day: 9 hr. 7 min.

9. Birthplace Baltimore (Town, county and state)

10. Usual Occupation Infant

11. Industry or business

FATHER — 12. Name Sidney Shapiro
13. Birthplace Baltimore

MOTHER — 14. Maiden Name Freda Lefkowitz
15. Birthplace Baltimore

16 (a) Informant 2920 Parkwood Ave
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JUN 30 1947

18 (a) Funeral director Commissioner of Health
(b) Address

JUL 1 1947 (Date rec'd by Registrar) Washington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1947, at 10 20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/28/47 to 6/28/47, and that I last saw h[illegible] alive on 6/28/47.

Immediate cause of death Respiratory failure — Duration

Due to Prematurity

Due to

Other Conditions Hydramnios

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Oswald Lupp M. D.
Address WBG Hospital Date signed 6/28/47

X

G53081

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G53081

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 119 So. Carey St
(c) Hospital or institution: [illegible] -18-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 119 So Carey St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William [illegible] Taylett

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Unknown
8. AGE: Years 50(?) Months Days If less than one day hr. min.
9. Birthplace Unknown (Town, county, and state)
10. Usual Occupation Unknown
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr Neal Burkett
(b) Address 119 So Carey St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/4/47 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem
Location Westminsburg W Va
18 (a) Funeral director John J Conway & Son
(b) Address 900 W Baltimore Street
19 JUL 1 1947 (Date rec'd by registrar) (b) Huntington West Virginia

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1947, at 9:45 PM
21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1 1941, to June 30 1947, and that I last saw h[illegible] alive on June 30 1947.

	Duration
Immediate cause of death: Coronary Occlusion	6 hrs
Due to: Arteriosclerotic Cardio Vascular Disease	?
Due to: —	
Other Conditions: —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury —
23. Signature Carl P Keating
Address 326 W Lombard St Date signed 7/4/47

C53082

BALTIMORE CITY HEALTH DEPARTMENT X ✓ C53082

CERTIFICATE OF DEATH

179 X

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Towson (If outside city or town limits, write RURAL and give town)
(d) Street No. 405 York Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Smercina

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Agnes E. Smrcina

6 (c) If alive, give age ///years

7. Birth date of deceased (mo., day, yr.) November 11, 1872

8. AGE: Years	Months	Days	If less than one day
74 10	7	19	hr. min.

9. Birthplace: Austria (Town, county, and state)

10. Usual Occupation: Clothing Retailer

11. Industry or business: Self

FATHER
12. Name: Vaclav Smrcina
13. Birthplace: Austria (?)

MOTHER
14. Maiden Name: Antonia Vitcha
15. Birthplace: Austria (?)

16 (a) Informant: Louis Machacek
(b) Address: 405 York Rd., Towson, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 3, 1947 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Harford Rd., Baltimore, Md.

18 (a) Funeral director: John Burns Son
(b) Address: Towson, Maryland

19 (a) JUL 1 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 131

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30, 1947, at 5:55 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Methyl salicylate phisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6/29/47 at appx 10 P. M.
(b) Where did injury occur? 405 York Road
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Drank oil of wintergreen by mistake

23. Signature George B. Merrill M.D. Medical Examiner.
Date signed 6/30/47

G53083

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 108

Registered No. G53083

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3322 Calvert Ste
(c) Hospital or institution: Lenox Hill Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days
(e) Length of stay in Baltimore (yrs., mos., or days) 6

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Lutherville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lottie A. PARKS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Wilbert J. Parks

6 (c) If alive, give age //// years

7. Birth date of deceased (mo., day, yr.) April 27, 1875

8. AGE: Years	Months	Days	If less than one day
72	2	3	..... hr. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation ~~Farmer~~ Nurse

11. Industry or business Housewife- At Home

FATHER
12. Name Wilbur Fitzpatrick
13. Birthplace Md

MOTHER
14. Maiden Name Maggie Wilson
15. Birthplace Md

16 (a) Informant Mrs. Robert E. Parks
(b) Address Lochearnvale Md.

17 (a) Burial (b) Date thereof July 3, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sater's Baptist Cemetery
Location Brooklandville, Balto. Co., Md.

18 (a) Funeral director John Burns' Sons
(b) Address Towson, Maryland

19 JUL 1 1947 (Date rec'd by Registrar) (c) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1947 at 1:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to June 30 1947.
and that I last saw her alive on June 30 1947.

Immediate cause of death	Duration
(a) Pneumonia - bilateral	1 week
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter Tunbert Jr. M. D.
Address Union Mem. Hosp. Date signed 6-30-47

53084

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

140 B

Registered No. C53084

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. 7-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) d o a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1024 Mc Donough St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Doris Blackwell

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3, 1930

8. AGE: Years	Months	Days	If less than one day
17	3	16	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Mack Blackwell
13. Birthplace Va.

MOTHER
14. Maiden Name Grace Stokes
15. Birthplace Va.

16 (a) Informant Grace Stokes
(b) Address 1024 Mc Donough St

17 (a) Removal (b) Date thereof July 2/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Crewe Virginia

18 (a) Funeral director Mrs. Wm. A. Elliott & Son
(b) Address 1129 N. Caroline St

19 (a) JUL 1 1947 Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/29 1947, at 10 A.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Incomplete abortion with infection

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner
Date signed 6/30/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G53085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

Registered No. G53085

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 Shakespeare St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wladyslaw Walter (Boardy) Borowy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband ~~of wife~~ Boleslawa
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1892

8. AGE: Years	Months	Days	If less than one day
55	1		hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Longshoreman
11. Industry or business

FATHER
12. Name Stanislaw Borowy
13. Birthplace Poland

MOTHER
14. Maiden Name Anna Zisk
15. Birthplace Poland

16 (a) Informant Boleslawa Borowy
(b) Address 1605 Shakespear St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 2/47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore

18 (a) Funeral director Fred W Ozarowski
(b) Address 1930 Eastern Ave

19 (a) July 2 1947 Date rec'd by Registrar Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-29- 1947, at 8 30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy Inspection or Inquiry (Autopsy, Inspection or Inquiry), find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑ (Probably), suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-29-47 at A.M.
(b) Where did injury occur? Harbor - Ft of Thames St
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? no
(d) Means of injury Fell from Bridge

23. Signature Carl C Hoyer M.D.
Medical Examiner.
Date signed 6-30-47

G53086

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 167

G53086
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 415 Druid Hill Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ralph JAMES

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14 1930

8. AGE: Years	Months	Days	If less than one day
16	9	14	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Ralph Harmon
13. Birthplace Va.

MOTHER
14. Maiden Name Emma Jane
15. Birthplace Md.

16 (a) Informant Jessie Rock
(b) Address 415 Druid Hill Ave

17 (a) Burial (b) Date thereof 7-2-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Pocomoke City
Location Maryland

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 JUL 2 1947 (b) Huntington Williams M.D.
(Date rec'd by Registrar)

B 98 761

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28, 1947 at 6 20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab-wound of left lung and heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6/28/47 6-30 P.M.
(b) Where did injury occur? Cor. 3 Druid Hill Ave & East Lane
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Sharp Instrument

23. Signature George F. Merrill M.D.
Medical Examiner

Date signed 6/28/47

G53087

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G53087

CERTIFICATE OF DEATH 137a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A. Arundel
(c) City or town Glenburnie (If outside city or town limits, write RURAL and give town)
(d) Street No. Glenburnie P.O. Md (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex Male | 5 Color or race Black | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~

6 (b) Name of husband or wife ?

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 10-25-73

8. AGE: Years 73 | Months — 8 | Days — 5 | If less than one day — hr. — min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Sam Smith
13. Birthplace Va.

MOTHER 14. Maiden Name Waynie Dickson
15. Birthplace Va.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-5-47 (month) (day) (year)
(c) Cemetery or crematory Marley Cem
Location Glen Burnie Md

18 (a) Funeral director William A Peakpson
(b) Address 916 Pennsylvania ave

(a) Date rec'd 1947 Huntington Williamsport Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-30-1947 at 9:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-5-47 to 6-30-1947; and that I last saw h[illegible] alive on 6-30-1947

	Duration
Immediate cause of death Uremia	2 mos
Due to Renal insufficiency	
Due to Hypertensive cardiovascular renal disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 4-11-47
Major findings of operation: BPH and extravasation of urine
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Johns Hopkins Hosp Date signed July 47

X

G53088

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G53088

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 Clifton Ave.
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 Clifton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen A. Myers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband ~~or wife~~ Earl T. Myers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8th 1904

8. AGE: Years	Months	Days	If less than one day
43	1	23	hr. min.

9. Birthplace Washington D.C.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name Thomas Cady
13. Birthplace Washington D.C.

MOTHER
14. Maiden Name Mary (Unknown)
15. Birthplace Mass

16 (a) Informant Earl T. Myers
(b) Address 2101 Clifton Ave

17 (a) Burial (b) Date thereof 7/3/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Moreland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) 7-2 1947 (Date rec'd by Registrar) (Huntington Williams, M.D.) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1st 1947, at 5:45 a. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/29 1944 to 7/1 1947 and that I last saw h~~er~~ alive on 6/30/1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to Hypertension	3 yrs ?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Weiss, M.D.
M. D.
Address 1927 E. North Ave. Date signed 7/1/47

X

G53090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G53090

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Good Samaritan Home for Incurables
(c) Hospital or institution: 227 N. Carey Street

(d) Length of stay in hospital or inst. (yrs., mos., or days): 3 1
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Maryland (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 417 S. Bond Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: Steve Bortoch

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife:
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 15th 1878

8. AGE: Years	Months	Days	If less than one day
69	0	14	hr. min.

9. Birthplace: Austria (Town, county, and state)
10. Usual Occupation: Karmkloyed
11. Industry or business:

FATHER
12. Name: Unknown Bortoch
13. Birthplace:

MOTHER
14. Maiden Name:
15. Birthplace:

16 (a) Informant: Mrs. Charles Hartley
(b) Address: 419 E Bond St

17 (a) Burial (Burial, ~~cremation or removal~~) (b) Date thereof July 3rd 1947 (month) (day) (year)
(c) Cemetery or ~~crematory~~: Cathedral
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul Street

JUL 2 1947 (Date rec'd by Registrar) Washington for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 29 1947 at 11 45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 25 1947 to June 29 1947 and that I last saw him alive on June 29 1947.

Immediate cause of death: Coronary Thrombosis
Etc. Hypertension

	Duration
Due to	5 yrs
Due to	5 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Milton L. Solomon M.D.
Address: 129 S. Bway Date signed: 6/30/47

G53091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 73a

G53091 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2304 Severnsdreet
(c) Hospital or institution: /
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2304 Severnsdreet
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dourhue Edna (Mary E.)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Dourhue William E

6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) June 18, 1894

8. AGE: Years 53 | Months — | Days 13 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore County (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name Charles Brown

13. Birthplace B'more Cty

MOTHER 14. Maiden Name Florence Purple

15. Birthplace Baltimore Cty

16 (a) Informant Dourhue Andrew

(b) Address 2304 Severnsdr

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/4/47 (month) (day) (year)

(c) Cemetery ~~or crematory~~ London Park

Location Balto. Md.

18 (a) Funeral director Williams Cook Inc.

(b) Address 1217 St. Paul St.

JUL 2 1947 (Date rec'd by Reg.) (b) Huntington Williams MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1rst 1947, at 10:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from aug 1946, to July 1 1947. and that I last saw her alive on June 30 1947.

Immediate cause of death Pernicious Anemia — Duration: approx. 2 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walther H Sonnenfeldt

Address 2708 Hollins Ferry Rd Date signed 7/3/47

× July 1rst 47

G53092 ✓ G53092

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2221 Barclay st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2221 Barclay St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry A. Phillips

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife: Janet R. Phillips

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18 1871

8. AGE: Years	Months	Days	If less than one day
76	0	13	hr. min.

9. Birthplace Trenton N. J.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business —

FATHER
12. Name Edward A. Phillips
13. Birthplace Unknown

MOTHER
14. Maiden Name Olga McKean
15. Birthplace "

16 (a) Informant Janet R. Phillips
(b) Address 2221 Barclay St.

17 (a) Removal (b) Date thereof 7/3/47
(~~Burial, cremation, or~~ removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Greenwood
Location Trenton N. J.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

JUL 2 1947 Huntington Williams MD
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1st 1947, at 3:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 27 1947 to July 1 1947, and that I last saw him alive on July 1st 1947.

Immediate cause of death Carcinoma of the Liver — Duration about 3 yrs.

Due to Cancer of the liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury Hard Tumor
23. Signature
Address 1623 E. N. Avenue Date signed 7/1/47

G53092 ✓ G53092

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45a

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2221 Barclay st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2221 Barclay st
(If rural give location)
(e) Citizen of foreign country? .....(Yes or No)
If yes, name country .....

3 (a) FULL NAME Harry A. Phillips

3 (b) If veteran, name war	3 (c) Social Security Account No.
ND	

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Janet R. Phillips
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 18th 1871

8. AGE: Years	Months	Days	If less than one day
76	0	13	..... hr. ..... min.

9. Birthplace Trenton N. J.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER
12. Name Edward A. Phillips
13. Birthplace Unknown

MOTHER
14. Maiden Name Clara McKean
15. Birthplace "

16 (a) Informant Janet R. Phillips
(b) Address 2221 Barclay st.

17 (a) Removal (b) Date thereof 7/3/47
(~~Burial, cremation, or~~ removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Greenwood
Location Trenton N. J.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul ste.

JUL 2 1947 Washington Williamsport
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1st 1947, at 3 15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 29 1947 to July 1st 1947, and that I last saw him alive on July 1st 1947.

Immediate cause of death Carcinoma of Rectum — Duration about 3 yrs.

Due to Cancer of the Liver

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of ~~autopsy~~: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work?
(Specify type of place)
(e) Means of injury .....
23. Signature Hart Traynor
Address 1625 E. N. Ave. Date signed 7/1 47

VS 150

G53093

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

G53093
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 33 days
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Ohio (b) County
(c) City or town Dayton
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1911 Dewitt Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick E. Hawk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-5-41

8. AGE: Years 5 | Months 6 | Days 27 | If less than one day — hr. — min.

9. Birthplace Ohio
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Thomas G. Hawk
13. Birthplace Ohio

MOTHER 14. Maiden Name Anna M. Hawbaek
15. Birthplace Ohio

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial, cremation, or removal Cremated (b) Date thereof 7/2/47 (month) (day) (year)
(c) Cemetery or crematory
Location Baltimore, Md.

18 (a) Funeral director Gallagher Funeral Home
(b) Address 3140 Cont

19 (a) 7-2 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

Vs 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-1-1947, at 8:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-29 1947, to 7-1-1947, and that I last saw h[illegible]ive on 7-1-1947

Immediate cause of death: CARDIAC FAILURE — Duration: 1 DAY
Due to: CONGENITAL HEART DISEASE — LIFE
Due to: (TETRALOGY OF FALLOT)
Other Conditions: SURGICAL ANASTOMOSIS OF LEFT SUBCLAVIAN-PULMONARY ARTERIES
(Including pregnancy within three months of death)
Date of operation 6/30/47
Major findings of operation: SAME
of autopsy: SAME

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard C. Clay, M.D.
Address Johns Hopkins Hosp. Date signed 7/2/47

G53094 Transcripts

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

✓ G53091 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3616 Oakmont Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3616 Oakmont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Winona Wallace

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	M

6 (b) Name of husband or wife John F. Wallace

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 29, 1892

8. AGE: Years	Months	Days	If less than one day
55	2	1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county and state)

10. Usual Occupation Nurse

11. Industry or business

FATHER
12. Name Harry E. Wolbert
13. Birthplace Nebraska

MOTHER
14. Maiden Name Willetta Morris
15. Birthplace Balto Co. Md.

16 (a) Informant Mr. John F. Wallace
(b) Address 3616 Oakmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-2-47 (month) (day) (year)
(c) Cemetery or crematory St Mary's Cemetery
Location Hampden Balto

18 (a) Funeral director Loring Byers
(b) Address 5205 Reisterstown Rd

JUL 2 1947 (Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30, 1947, at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947 to June 30 1947, and that I last saw h alive on 6/30 1947.

Immediate cause of death: acute cardiac dilatation — Duration: 2dy

Due to: chronic myocarditis — Duration: 4 mos

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature S. C. Feldman

Address 1442 E Balt St Date signed 7/2/47 (M. D.)

G53095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

467

G53095 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Mem. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Bradford Apts. 3 St Paul St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LILIAN OLIVIA GLADDING

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Fem.
5. Color or race: W
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 4, 1878

8. AGE: Years 68 | Months 7 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation School teacher (retired)
11. Industry or business Balto. City Dept. Edu.

FATHER
12. Name Charles Allan Gladding
13. Birthplace R. I. (?)

MOTHER
14. Maiden Name Olivia Ward
15. Birthplace Baltimore Md.

16 (a) Informant Mr. Allan M. Gladding
(b) Address 1528 Shadyside Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/3/47 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Baltimore, Md

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JUL 2 1947 (Date rec'd by registrar) (Operating for Williams, M.D.) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1947 at 5 pm M

21. I certify that death occurred on the date above stated; that I attended deceased from June 30 19__ to June 30 1947 and that I last saw h[er] alive on June 30 1947.

Immediate cause of death: Intestinal Obstruction — Duration: 6 days
Due to: Recurrence of Pretongue Ca — ?
Due to:
Other Conditions: Pulmonary tuberculosis
(include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Rawlings M. D.
Address Union Mem. Date signed

Hosp X 6-30-47

G53096

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G53096 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 929 St Paul St
(c) Hospital or institution: H

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 929 St Paul St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Holger B. Jespersen

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mila Jesperson (nee Culk)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1893

8. AGE: Years	Months	Days	If less than one day
54	6	0	hr. min.

9. Birthplace Denmark
(Town, county, and state)

10. Usual Occupation Consul

11. Industry or business

FATHER
12. Name Emil J. Jespersen
13. Birthplace Denmark

MOTHER
14. Maiden Name Magrete Pontoppidan
15. Birthplace Denmark

16 (a) Informant Mrs. Mila Jespersen
(b) Address 929 St. Paul St.

17 (a) Cremation (b) Date thereof July 5, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19. JUL 2 1947 (Date rec'd by Registrar) (By) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1st 1947, at 1:30 P.M.

21. I certify that I took charge of the remains described above, held an Aug Ex Insp thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Helbuck M.D.
Medical Examiner.
Date signed July 1st 1947

correct age is especially important. Physicians: please write the

G53097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 B

Registered No. G53097

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3124 Windsor Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3124 Windsor Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ralph H. Wyman

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War #1	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Ethel H. Wyman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1898

8. AGE: Years	Months	Days	If less than one day
49	4	17	hr. min.

9. Birthplace Maine (Town, county, and state)
10. Usual Occupation coffee salesman
11. Industry or business Great American Tea Co.

FATHER
12. Name Nathan Wyman
13. Birthplace Maine

MOTHER
14. Maiden Name Lottie Ryan
15. Birthplace Maine

16 (a) Informant Mrs. Ethel H. Wyman
(b) Address 3124 Windsor Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/3/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetary
Location Woodlawn, Maryland

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Baltimore, Maryland

19 (a) JUL 2 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1, 1947, at 6.20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 7, 1947, to July 1, 1947, and that I last saw h im alive on July 1, 1947.

Immediate cause of death: Cirrhosis of the liver — Duration: since Feb. 7, 47

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George A. Kupp M. D.
Address 3030 Edmondson Ave. Date signed 7/1/1947

G53098

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G53098

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 240 N. Patterson Park Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 240 N. Patterson Park Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Rehberger

3 (b) If veteran, name war ---
3 (c) Social Security Account No. ---

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William Rehberger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3, 1875

8. AGE: Years 72 | Months 0 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Peter Schaflein
13. Birthplace Germany

MOTHER
14. Maiden Name Matilda ----
15. Birthplace Germany

16 (a) Informant Wm. Rehberger
(b) Address 240 N. Patterson Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 3, 1947 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto. Md.

18 (a) Funeral director Philip Sterling Sons
(b) Address 2024 Orleans St.

19 (a) July 2 1947 (Date rec'd by local registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29/47 19 . at 240 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from January 9 1947 to June 29 1947. and that I last saw h[illegible] alive on June 29 1947.

Immediate cause of death: Cerebral Hemorrhage — Duration: 1 Day

Due to: Diabetes Mellitus — 5 Years
Chronic Interstitial Nephritis
Arterial Hypertension

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Rosenberg, M.D.
Address 2035 E. North Ave. Date signed 7-1-47

X

G53099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G53099 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 30 Benkert Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) na
(e) Length of stay in Baltimore (yrs., mos., or days) 85 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 30 Benkert Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph F. Yates

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Wilhelmina M Yates
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26 1896

8. AGE: Years 51 | Months 2 | Days | If less than one day hr. min.

9. Birthplace Washington D.C.
(town, county, and state)

10. Usual Occupation Plumber
11. Industry or business self

FATHER
12. Name Joseph F. Yates
13. Birthplace Washington D.C.

MOTHER
14. Maiden Name Elizabeth Sperry
15. Birthplace Baltimore Md

16 (a) Informant Wilhelmina Yates
(b) Address 30 Benkert Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 3-47 (month, day) (year)
(c) Cemetery or crematory Lorraine Park
Location

18 (a) Funeral director Chas P Powell
(b) Address 2427 Edmondson Ave

19 (a) JUL 2 1947 (Date received by registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1947, at 11:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 18 March 1947 to 29 June 1947, and that I last saw h.wife alive on 29 June 1947.

Immediate cause of death	Duration
Acute Cardiac failure	Immediate
Due to Marasmus	2 months
Due to Carcinomatosis of liver	Undetermined
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Exploratory May
Major findings of operation: Carcinoma of liver
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles Cumnock M.D.
Address 910 W. Lombard St Date signed 7-47

G53100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56E

G53100 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1536 N. Gilmore St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	WIDOW

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1883

8. AGE: Years	Months	Days	If less than one day
53	7	6	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation DOMESTIC.

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Blanch Russell
(b) Address 3315 Patterson ave

17 (a) Burial (b) Date thereof July 2-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Brooklyn Md.

18 (a) Funeral director Elroy B. Watson
(b) Address 1000 Hamilton ave

JUL 2 1947 (a) (b) Huntington Williams
(Date received) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1947, at 6:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 4 19 47 to June 29 19 47, and that I last saw her alive on June 28 19 47

Immediate cause of death Pulmonary Embolism — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation June 23 1947

Major findings of operation: Adenoma, prostate.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles R. MacDonald

Address 1213 Light St. Date signed M. 6 D. 30/47

C53101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓107

C53101
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 917 N. Port Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore ✓
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick J. BOEDDEKER

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 216-01-7766-A

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widower

6 (b) Name of husband or wife: late Catherine (Nee Bergen)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 30, 1876

8. AGE: Years 70 | Months 9 | Days - | If less than one day ... hr. ... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: League Lumber Company

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden Name: Unknown
15. Birthplace

16 (a) Informant: Mrs. Teresa Derr (daughter)
(b) Address: 917 N. Port Street, Zone 5

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/2/47 (month) (day) (year)

(c) Cemetery or crematory: Baltimore Cemetery
Location: North & Rose St.,

18 (a) Funeral director: Charles E. Schimunek
(b) Address: 2601-03 East Madison Street.

19 (a) Filed 2 by reg 1947 (b) Thurlington Williams, M.D.

VS Form

MEDICAL CERTIFICATION A.

20. DATE OF DEATH June 30, 1947 19 ... at 9:30 M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/30 19 47 to 6/30 19 47.
and that I last saw h[illegible] alive on 6/30 19 47.

Immediate cause of death	Duration
Bronchopneumonia	4 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Frederick C. Mansueti M. D.
Address 333 S. Ponca St. Date signed 7/2/47

X

G53102

BALTIMORE CITY HEALTH DEPARTMENT

Registered No. G53102

COVAHEY CERTIFICATE OF DEATH 1314

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 124 Union Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 124 Union Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Covahey

3 (b) If veteran, name war: 910

3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife: John F Covahey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 25, 1861

8. AGE: Years	Months	Days	If less than one day
86	3	5	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Patrick McNeve
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Lanahan
15. Birthplace Ireland

16 (a) Informant Mrs. Joseph F. Bilson
(b) Address 124 Union Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 3 / 47 (month) (day) (year)
(c) Cemetery or crematory Mt. Cathedral Cemetery
Location 4300 Old Frederick Rd.

18 (a) Funeral director Edgar H. Franklin Son
(b) Address 920 E. Eager St.

JUL 2 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30, 1947, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1947, to June 30 1947, and that I last saw her alive on June 30 1947.

Immediate cause of death	Duration
Rt. Cerebral Thrombosis	10 days
Due to Cardio-Renal-Vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. F. Wilson

Address 617 W 40th St Date signed 7/1/47 D

X

C53103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

C53103
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2233 Orleans st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2233 Orleans St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vincent Pasternak

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-4560

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Josefa

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 73 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Vincent Pasternak
13. Birthplace Poland

MOTHER
14. Maiden Name Agata Kalak
15. Birthplace Poland

16 (a) Informant Josephine Pasternak
(b) Address 2233 Orleans St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-4-47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location Balto. Co.

18 (a) Funeral director Wm. L. Fialkowski
(b) Address 2007 Eastern Ave

JUL 2 1947 (b) Huntingtown, Williamsport, Md.
(Date rec'd by local reg.)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1946 to June 30 1947, and that I last saw h alive on June 30 1947.

Immediate cause of death — Duration

Due to Acute Cardiac Dilat 6/30/47

Due to Carcinoma of Lung 11/1/46

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William L. Ryan M.D.
Address 801 W Lexington Date signed 7/1/47

X

G53104

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

G53104 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital 57

2. USUAL RESIDENCE OF DECEASED:
(a) State Mass. (b) County
(c) City or town New Bedford
(If outside city or town limits, write RURAL and give town)
(d) Street No. 402 ½ Front St.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Scotland

(d) Length of stay in hospital or inst. (yrs., mos., or days) 78 days
(e) Length of stay in Baltimore (yrs., mos., or days) 78 days

3 (a) FULL NAME Robert Suddaby

3 (b) If veteran, name war	3 (c) Social Security Account No. 021-14-2062

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1876 1886

8. AGE: Years	Months	Days	If less than one day
60	2 7	15 6	hr. min.

9. Birthplace Scotland (Town, county, and state)
10. Usual Occupation Deckhand
11. Industry or business Seafarer

FATHER
12. Name Joseph Suddaby
13. Birthplace Scotland

MOTHER
14. Maiden Name Mary ?
15. Birthplace Scotland

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 2-47 (Month) (Day) (Year)
(c) Cemetery or crematory Lorraine Presbyterian
Location Balto Maryland

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave

JUL 2 1947
(Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1947, at 6:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 11 1947 to June 28 1947, and that I last saw him alive on June 28 1947

	Duration
Immediate cause of death (1) Primary bronchogenic caroinoma	Unknown
(2) Metastases to liver, both ~~Duo to~~ kidneys, spleen & intestines	Unknown
(3) Abscess and atelectasis left ~~Due to~~ lung, due to tumor	Unknown
(4) Edema and congestion right ~~Other Conditions~~ lung	Unknown

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
As above
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 6/30/47

X

G53105

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G53105 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 412 S Pulaski St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No 412 S Pulaski St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Maggie A. Friel

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Joseph J.

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 4 1864

8. AGE: Years 83 | Months | Days 27 | If less than one day ... hr. ... min.

9. Birthplace St Marys Co Md (Town, county, and state)

10. Usual Occupation House work

11. Industry or business at home

FATHER — 12. Name James H Sanders

13. Birthplace England

MOTHER — 14. Maiden Name Amelia Conklin

15. Birthplace Norway

16 (a) Informant Mr Joseph J Friel

(b) Address 412 S Pulaski St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/4/47 (month) (day) (year)

(c) Cemetery or crematory St Andrews Cem

Location St Marys Co Md

18 (a) Funeral director Bluff Bowen & Son

(b) Address 961-63 Hollins St

JUL 2 1947 (Date rec'd by Local Registrar) (b) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1st 1947 at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1947 to July 1 1947 and that I last saw her alive on June 30 1947.

Immediate cause of death	Duration
Cerebral hemorrhage	
Respiratory failure	
Due to Cerebral hemorrhage	
Due to Arteriosclerosis	
Other Conditions Generalized Art Sclr Art. Sclr Card. Uraec. Diseases	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature K. Krukenberg M. D.

Address 2116 W. Pratt St Date signed 7/1/47

83a

G53106 NH

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1 2 B

G53106 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 months
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 515 N. Parrish St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dora Horsey

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife Frederick Horsey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 10, 1925

8. AGE: Years	Months	Days	If less than one day
22	5	13	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Bagwell
13. Birthplace Virginia

MOTHER
14. Maiden Name Annie Gleamer
15. Birthplace Virginia

16 (a) Informant Records at Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-2-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion.
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St.

19 JUL 2 1947 (Date rec'd by Reg.) (b) Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 23 1947, at 10:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 24 1947 to June 23 1947, and that I last saw her alive on June 23 1947.

Immediate cause of death	Duration
RESPIRATORY FAILURE	
Due to FAR ADVANCED BILATERAL PULMONARY	1 YEAR
Due to TUBERCULOSIS	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry J Houska M.D.
Address Balto City Hosp. Date signed 6/30/47

C53107 AL - 99795

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

Registered No. C53107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3036 S. Land Ave. Cherry Hill
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Chapman

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Sep.

6 (b) Name of husband or wife Jesse
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7, 1888

8. AGE: Years	Months	Days	If less than one day
59	2	20	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Peter Cana
13. Birthplace Va.

MOTHER
14. Maiden Name Elnora Badger
15. Birthplace Va.

16 (a) Informant B/ C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 7-2-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

JUL 2 1947 Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27, 1947 at 8.55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 8 1946 to June 27 1947, and that I last saw her alive on June 27 1947

Immediate cause of death	Duration
Bronchopneumonia	7da.
Due to	
Due to	
Other Conditions Diabetes Mellitus	5 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature William M. Straight M. D.
Address 4940 Eastern Ave Date signed 7-1-47

107

G53108 G53108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3713 Reistertown Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3713 Reistertown Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abraham D. Barron

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years	Months	Days	If less than one day
79			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name Benjamin
13. Birthplace Russia

MOTHER 14. Maiden Name Hatze
15. Birthplace Russia

16 (a) Informant Dena Barron
(b) Address 3713 Reistertown Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-2-47 (month) (day) (year)

(c) Cemetery or crematory
Location Hebrew Mt Carmel

18 (a) Funeral director Jack Lewis Inc
(b) Address 439 E Balto St

JUL 2 1947 (Date rec'd by local registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-1-1947 (3 A M) 45

21. I certify that death occurred on the date above stated; that I attended deceased from 1925 to 7-1-1947.
and that I last saw h alive on 6-30-1947.

Immediate cause of death	Duration
Acute Myocardial Insufficiency	1 hour
Due to Chr. Myocardial Insuff.	2 years
Due to Generalized Arterio sclerosis	20 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jack Cohen M. D.
Address 1804 Eutaw Place Date signed 7/1/47

C53109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. C53109

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3300 Roland Ave
(c) Hospital or institution: Kirkleigh Villa
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4201 Roland Ave Kirkleigh Villa (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary de Hemelt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, widowed, or divorced
Fem	White	Widow

6 (b) Name of husband or wife Charles J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6 1860

8. AGE: Years	Months	Days	If less than one day
87	2	24	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER 12. Name Francis J. Eder
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Francis A. Franz
15. Birthplace Baltimore

16 (a) Informant Rev Fr Hemelt
(b) Address St Mary Govn

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 3 (month) (day) 47 (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore Md

18 (a) Funeral director John G Horan
(b) Address 3600 E Baltimore St

JUL 2 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1947 at 2:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1947 to June 30 1947, and that I last saw h alive on June 29 1947.

Immediate cause of death Myocardial Insufficiency — Duration 3 days

Due to Myocarditis — 4 yrs

Due to Arteriosclerosis — 4 yrs

Other Conditions Coronary Obstruction — 1 year

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas J. Meik M. D.
Address 532 E 22 St Date signed 6/30/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G53110

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 617 N Carlton
(c) Hospital or institution:
16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 617 N Carlton (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Curtis

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Married

6 (b) Name of husband or wife Benj. Curtis
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) June 15 90

8. AGE: Years	Months	Days	If less than one day: hr.	min.
57	54	65		

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Jackson Jones
13. Birthplace Md

MOTHER
14. Maiden Name E Coates
15. Birthplace Md

16 (a) Informant Benj - Curtis
(b) Address 617 N Carlton

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/3/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Md

18 (a) Funeral director Kelly B. Nelson
(b) Address 1303 Presstman St

19 (a) JUL 2 1947 Huntington Hilliard (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1947, at 3 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947, to June 30 1947
and that I last saw her alive on June 30 1947

Immediate cause of death	Duration
Cerebral hemorrhage	3 hrs
Due to Hypertension	4 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature W. H. Watts
Address 575 Whelan Date signed 7/2/47

VS 150

G53111 | BALTIMORE CITY HEALTH DEPARTMENT | G53111

CERTIFICATE OF DEATH 1947

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 658 Sarah Ann St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 658 Sarah Ann St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cecilia Thompson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1892

8. AGE: Years 54 | Months 7 | Days | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Horace Lee
13. Birthplace Easton, Maryland

MOTHER
14. Maiden Name Susan Blackstone
15. Birthplace Easton, Maryland

16 (a) Informant Bertina Smith
(b) Address 664 Bradley Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-2-47 (month) (day) (year)
(c) Cemetery or crematory Ant. Calvary
Location

18 (a) Funeral director Adolphus Hofstead
(b) Address 91 Pulaski Hill Ave. Washington Hill, Md.

19 (a) JUL 2 1947 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 27, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-22 1947 to 6-27-1947 and that I last saw h[illegible] alive on 6-25-1947.

Immediate cause of death: Hypertensive Cardio Vascular Disease Jr.

Duration

Due to

Due to

Other Conditions Fibromyoma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Atwell Jones M. D.
Address 554 Dolphin Date signed 7-2-47

V S 150

G53112

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 167

G53112
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 573 Moore st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Perkins

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-10-5536

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 56 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Jennie Perkins
(b) Address 573 Moore St.

17 (a) Burial (b) Date thereof 7-8-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 (a) 1947 (b) Huntington-Williams Memorial
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/29 1947, at 3:50 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hemorrhage due to stab wound of heart
Due to Severance of carotid artery, left.
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6/29/47 3 A. M.
(b) Where did injury occur? 573 Moore st
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Stabbed - sharp instrument

23. Signature Earl L Royer M.D.
Medical Examiner.
Date signed 6-30-47

X

G53113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

G53113
Registered No.

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Incorrect age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Providence Hospital 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 14
(If outside city or town limits, write RURAL and give town)
(d) Street No. 927 Jordan st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Townsend

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years	Months	Days	If less than one day
43			hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Richard Lockett
13. Birthplace Va.

MOTHER
14. Maiden Name Bettie
15. Birthplace N.C.

16 (a) Informant Bettie Townsend
(b) Address 927 Jordan St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-3-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Avenue

19 (a) 1947 (Date rec'd by registrar) Winterton Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION 15

20. DATE OF DEATH 6/27 1947, at 10 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑ undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Contusion - Cranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-26-47 at 12:15 P. M.
(b) Where did injury occur? 927 Jordan st
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Struck on head by broom handle

23. Signature Earl L Kruger M.D.
Medical Examiner
Date signed 6-27-47

G53114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G53114 Registered No.

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3217 Fleet St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 76
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3217 Fleet St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET M. ZIPFEL

3 (b) If veteran, name war ----
3 (c) Social Security Account No. ------

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife John Zipfel
6 (c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) June 24, 1872.

8. AGE: Years 75 | Months 0 | Days 6 | If less than one day ..... hr. ..... min.

9. Birthplace Hausheim, Germany
(Town, county, and state)
10. Usual Occupation House-Work
11. Industry or business At home.

FATHER
12. Name August Reiser
13. Birthplace Germany.

MOTHER
14. Maiden Name ? Marks
15. Birthplace Germany

16 (a) Informant John Zipfel (Husband)
(b) Address 3217 Fleet St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-3-47. (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location German Hill Rd. Ba. Co., Md.

18 (a) Funeral director Charles S. Zeiler.
(b) Address 3605 Fait Ave.

19 (a) 1947 (by registrar) (b) ..... Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1947, at 2:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947. to June 30 1947
and that I last saw her alive on June 30 1947.

Immediate cause of death: Diabetes Mellitus — Duration: 1 year
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank A. Glantz M.D.
Address 1 Wendover Road - 18 Date signed July 1-47

X

G53115

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 124a

G53115
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1076 W. Fairmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elonar SIMMS

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-225

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Helen Simms

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1910

8. AGE: Years 37 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Helen Simms
(b) Address 1076 W. Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/3/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location West Port Balto. Md.

18 (a) Funeral director Metropolitan Funeral Home
(b) Address 927 N. Mount St.

(a) Date rec'd JUL 2 1947 (b) Registrar Huntington Williams, M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1947, at 10 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute alcoholism
Fat infiltration of liver
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 6/30/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53116

G53116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH v 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4112 Hamilton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4112 Hamilton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank B Berry

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary Berry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 3 - 1871

8. AGE: Years 76 | Months 3 | Days 28 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Furniture Finisher
11. Industry or business

FATHER
12. Name Geo Berry
13. Birthplace Balto

MOTHER
14. Maiden Name Mary Boswell
15. Birthplace Balto

16 (a) Informant Mary Berry
(b) Address 4112 Hamilton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 3 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Rural

18 (a) Funeral director Gellrich Funeral Home
(b) Address 2108 Orleans St

19 (a) JUL 2 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1st 1947, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1947, to July 1 1947, and that I last saw h[illegible] alive on June 1st, 1947.

Immediate cause of death Coronary occlusion — Duration

Due to

Due to

Other Conditions Senile debility & malnutrition
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bernard F. French, M.D.
Address 2329 Arunah Date signed 7/1/47

G53117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

G53117

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 17
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1820 Riggs Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Reid ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Estelle Reid

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 6, 1901

8. AGE: Years 46 | Months 6 | Days 24 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business Privately Employed

FATHER 12. Name Robert Reid

FATHER 13. Birthplace Virginia

MOTHER 14. Maiden Name Bessie Reid

MOTHER 15. Birthplace N. Carolina

16 (a) Informant Estelle Reid

(b) Address 1821 Riggs Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 3, 1947 (month) (day) (year)

(c) Cemetery or crematory Mt. Zion Cemetery

Location Baltimore, Md.

18 (a) Funeral director Jno. Law H. Holland

(b) Address 1631 Druid Hill Ave

2 1947 (a) (Date received by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-30 1947 at 11:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-20 1947 to 6-30 1947 and that I last saw h[illegible] alive on 6-30 1947

Immediate cause of death Cardiac Decomp. + Failure — Duration 3 days

Due to Luetic Aortitis — 3 yrs

Due to Lues — ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William D. Beatty Jr.

Address Mercy Hosp. Date signed 6-30-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G53118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G53118

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St.
(c) Hospital or institution: Home for the Aged Const
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Grant

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	C.	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Mark Grant
13. Birthplace

MOTHER 14. Maiden Name Rachael —
15. Birthplace

16 (a) Informant Lillie Linton Fe Core
(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 2 1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 East Biddle St

19 (a) July 2 1947 (Date received by registrar) (b) Registrar

VS 150

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1947, at 1.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947 to July 2 1947, and that I last saw him alive on July 1 1947.

Immediate cause of death	Duration
Edema Lungs	2 days
Due to Chronic Myocarditis	5 yrs.
Due to	
Other Conditions Chronic Endocarditis	6 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. D.
Address 16 W. Read St. Date signed 7-2-47

G53119

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

G53119
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 735 N. Kenwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mason H. Gilbert

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-07-9460

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	m

6 (b) Name of husband or wife Verna M. Grent
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 9, 1891

8. AGE: Years	Months	Days	If less than one day
56	3	21	hr. min.

9. Birthplace Lynchburg Va. (Town, county, and state)
10. Usual Occupation Engneer
11. Industry or business B & O R.R.

FATHER
12. Name Ludlow
13. Birthplace Lynchburg Va.

MOTHER
14. Maiden Name not known
15. Birthplace " "

16 (a) Informant Wife
(b) Address 2710 Tivoly Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/3/47 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Pk.
Location Taylor Ave.

18 (a) Funeral director Joseph J. Herr & Son
(b) Address 3001 Kentucky Ave.

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

JUL 2 1947

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1947 at 9:5 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion; Hypertrophy and dilatation of heart; Chronic myocarditis; chronic endocarditis; intramural thrombus; arteriosclerosis

Due to

Other Conditions Edema of brain; Congestion of lungs

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D. Medical Examiner.
Date signed 6-30-47

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53120 Humiliatas G53120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 901 Aisquith
(c) Hospital or institution:
Convent of Notre Dame
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 901 Aisquith St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sr. M. Humilitas Collins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 20, 1862

8. AGE: Years	Months	Days	If less than one day
65	4	11	hr. min.

9. Birthplace New York City
(Town, county, and state)
10. Usual Occupation Religious
11. Industry or business

FATHER
12. Name William Collins
13. Birthplace Boston

MOTHER
14. Maiden Name Ellen Clancy
15. Birthplace Ireland

16 (a) Informant Sr. M. Stan Krotter
(b) Address 901 Aisquith Street

17 (a) Burial (b) Date thereof July 4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Notch Cliff
Location Glen Arm

18 (a) Funeral director Geo M. Fritz Son
(b) Address 811 N Wolfe st

19 (a) (b)
(Date received) (Registrar) Registrar

V.S.A. VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1947, at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 17 1947, to July 1 1947, and that I last saw h alive on June 30 1947.

Immediate cause of death	Duration
Congestive heart failure	
Due to Cholecystitis with gallstones	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. J. Kirby
Address 1102 E Monument St Date signed

X 6962

G53121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G53121

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9days
(e) Length of stay in Baltimore (yrs., mos., or days) 62yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County St. Mary's
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. LEXINGTON PARK. (If rural give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER L HUDSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: MALE

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: MARY HUDSON

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APR. 18, 1885

8. AGE: Years 62 | Months 2 | Days 13 | If less than one day hr. min.

9. Birthplace BALTIMORE, Md. (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business —

FATHER
12. Name JOHN L. HUDSON
13. Birthplace NEW JERSEY

MOTHER
14. Maiden Name SARAH CASSEN
15. Birthplace PENNSYLVANIA

16 (a) Informant Records
(b) Address Mercy Hospital

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 7/3/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 S. Paul St

19 (a) JUL 3 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1947 at 1:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947 to July 2 1947 and that I last saw him alive on July 1 1947

Immediate cause of death: CEREBRAL Apoplexy — Duration

Due to: HYPERTENSIVE CARDIA

Due to: VASCULAR DISEASE

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. B. Scott M.D.
Address Mercy Hospital Date signed 7/2/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

D. 53122 / 93c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green Sts
(c) Hospital or institution: University Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3603 Parkside Drive
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lora E. Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) ~~Single, married~~ widowed, or ~~divorced~~: Widowed

6 (b) Name of husband August Miller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec 3rd 1878

8. AGE: Years 68 | Months 6 | Days 29 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Andrew Mihm
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Mainkrantz
15. Birthplace Unknown Penna.

16 (a) Informant Mrs Irene Middleton
(b) Address 752 Bartlett Ave

17 (a) Burial (b) Date thereof 7/5/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1947, at 1:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 18 1947 to July 2 1947 and that I last saw him alive on July 2 1947

Immediate cause of death	Duration
Coronal embolism Pulmonary Embolism	
Due to Phlebitis Cardiovascular Disease	Indefinite
Due to	
Other Conditions Prostatism (Include pregnancy within 3 months of death)	

Date of operation None

Major findings of operation: Pulmonary Embolism

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David T. Phillips M. D.
Address University Hosp. Date signed 7/2/47

X

G53123
516895

BALTIMORE CITY HEALTH DEPARTMENT X
CERTIFICATE OF DEATH ✓ 94a

G53123
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Kent
(c) City or town Rock Hall
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Ida A Kelley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) ~~Single, married~~, widowed, or divorced: Widowed

6 (b) Name of husband: Harry S. Kelley
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) 3-5-75

8. AGE: Years 72 | Months 3 | Days 27 | If less than one day: hr. min.

9. Birthplace: Rock Hall Md (Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: Robt Porter
13. Birthplace: Md.

MOTHER
14. Maiden Name: Henrietta Elburn
15. Birthplace: Md

16 (a) Informant: Records.
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 7/5/47 (month) (day) (year)
(c) Cemetery or ~~crematory~~: Wesley Chapel
Location: Rock Hall Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 127 St. Paul St.

19 JUL 3 1947 Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

A

20. DATE OF DEATH July-2 1947 at 6.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 9 1947 to July 2 1947 and that I last saw her alive on July-2 1947.

Immediate cause of death: CORONARY THROMBOSIS
CARDIAC FAILURE
Due to: CORONARY ARTERIO SCLEROSIS
Due to:
Other Conditions: CEREBRAL ART-
ERIOSCLEROSIS
(Include pregnancy within 3 months of death)

Duration

Date of operation:
Major findings of operations: ABOVE
of autopsy: ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Truman D. Thompson M. D.
Address: Johns Hopkins Hosp. Date signed 7-2-47

VS 150

G53124

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH ✓183

Registered No. G53124

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Montgomery
(c) City or town Silver Spring (If outside city, town limits, write RURAL and give town)
(d) Street No. 619 Meniffee Ave (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Herbert Vernon Morningstar

3 (b) If veteran, name war: W. W. #2

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1909

8. AGE: Years 38 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Archie Morningstar
13. Birthplace Md

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Wm Hilton
(b) Address Poolesville - Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-6-47 (month) (day) (year)
(c) Cemetery or crematory Monocacy
Location Bellsville Md.

18 (a) Funeral director Wm. Hilton
(b) Address Poolesville Md

19 (a) Date rec'd by Local Reg. JUL 8 1947 (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-1- 19 47 at 6 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7/1/47 at 5 P.M.
(b) Where did injury occur? Pier 6 - Pratt st
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Rolled into water from Pier

23. Signature ..... M.D. Medical Examiner.
Date signed 7-2-47

correct age is especially important. Physicians: please write the c

053125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83B

Registered No. 053125

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring Ave
(c) Hospital or institution: Levindale
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 - 2
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2209 Brookfield ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HARRY SIEGELMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Morton
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Mary Siegelman
(b) Address 2209 Brookfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-3-47 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Herring Lane

18 (a) Funeral director Jack Levin & Sons
(b) Address 1429 E Balto St

19 (a) JUL 3 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-2 1947 at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-29 1946 to 7-2 1947 and that I last saw h[illegible] alive on 7-2 1947

Immediate cause of death [illegible] Cerebral Thrombosis — Duration

Due to — Duration

Due to — Duration

Other Conditions Hypertension — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Vogel M. D.
Address Levindale Home Date signed 7-2-47

G53126

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G53126
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2504 Keyworth Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 12
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2504 Keyworth ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Kramer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Deceased

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Abraham
13. Birthplace Russia

MOTHER
14. Maiden Name Kelan
15. Birthplace Russia

16 (a) Informant Deceased Kramer
(b) Address 2504 Keyworth ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-3-47 (month) (day) (year)
(c) Cemetery or crematory Adas Israel
Location No Point & Germans Hill Rd

18 (a) Funeral director Jack Lewis Inc
(b) Address 439 S Dallo St

19 JUL 3 1947 (Registrar's signature) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-3- 1947, at 7A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1937 to 7/3, 1947 and that I last saw h[illegible] alive on 7/2, 1947.

Immediate cause of death	Duration
Arteriosclerotic Cardio-Vascular Disease	Several years
Due to	
Due to	
Other Conditions Coronary Thrombosis	1 day

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. A. Swosman M.D.
Address 1105 N. Calvert St Date signed 7/3/47

C53127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. C53127

CWK-111515

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eatern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 Days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1371? N. Gilmor Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jonas Bedford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July-- 1861

8. AGE: Years	Months	Days	If less than one day
85	11		hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Bedford
13. Birthplace ?

MOTHER
14. Maiden Name Elizabeth
15. Birthplace ?

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof July 3-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Brooklyn

18 (a) Funeral director Wm. Brooks
(b) Address 1437 Carey St

19 (a) JUL 3 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1947, at 5:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 18 1947, to June 29 1947, and that I last saw h. im alive on June 29 1947.

Immediate cause of death	Duration
Bronchopneumonia	
Due to Pulmonary Congestion	
Due to Arteriosclerotic Heart Disease & Heart Failure	
Other Conditions Malnutrition, Generalized arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. R. Harborway M. D.
Address Balto City Hosp Date signed 7-2-47

X

G53128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G53128

"PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1413 N. Caroline St.
(c) Hospital or institution:
none
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1413 N. Caroline St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Pamela J. Reddish

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Louis A. Reddish
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8, 1848

8. AGE: Years	Months	Days	If less than one day
99	4	23	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Marion DeKalb
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Martha Metz
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Marian L. Reddish
(b) Address 1413 N. Caroline St.

17 (a) Burial (b) Date thereof 7/4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John A. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 JUL 3 1947 (b) Huntingtown, Williamsport, Md.
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1, 1947, at 7-30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1947, to July 1 1947, and that I last saw her alive on July 1, 1947.

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Chronic Myocarditis	5 yrs
Due to	
Other Conditions Arteriosclerosis	20 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place)
While at work?
(e) Means of injury

23. Signature E. Bell Hall - M.D.
M. D.
Address 1631 E. North Ave. Date signed 7/2/47

VS 150

X

G53129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G53129 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3602 Windsor Mill Road
(c) Hospital or institution:
none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3602 Windsor Mill Road
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Annie M. Crowl

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife H. Webster Crowl
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1859

8. AGE: Years	Months	Days	If less than one day
87	8	25	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name James W. Flack
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary E. Baker
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Naomi A. Crowl
(b) Address 3602 Windsor Mill Road

17 (a) Burial (b) Date thereof 7/3/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~crematory~~ Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1906 Eutaw Place

19 (a) JUL 3 1947 (b) Huntington for Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1947, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 30 1947 to June 30 1947 and that I last saw h~~e~~r alive on June 27 1947.

Immediate cause of death: Myocarditis — Duration about 3 mo

Due to: Advanced arteriosclerosis ?

Due to: —

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Hallie Dillard M. D.
Address 2220 Garrison Blvd. Date signed July 1/47

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C53130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. C53130

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 415 Bruce St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-1
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 415 Bruce St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Webster Elliott.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed.

6 (b) Name of husband or wife M. Jettie Elliott.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28-1872.

8. AGE: Years	Months	Days	If less than one day
75	1	24	hr. min.

9. Birthplace Calvert Co. Md. (Town, county and state)
10. Usual Occupation Carpenter.
11. Industry or business

FATHER
12. Name Boston Elliott.
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Weisman.
15. Birthplace Md.

16 (a) Informant Mrs. Ford Elliott.
(b) Address 772 Frontyard St.

17 (a) Burial. (b) Date thereof July 3/47.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location

18 (a) Funeral director Charles J. Schwab.
(b) Address 3512 Frederick Ave.

19 (a) Filed by reg. JUL 3 1947 (b) Thurlow for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1st. 1947. at 1:45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947 to July 1 1947 and that I last saw him alive on June 30 1947.

Immediate cause of death	Duration
Malignancy of left nude by breast	March 1946
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify home, farm, industrial place, etc.)
(e) Means of injury

23. Signature [illegible] M.D.
Address 4362 Fort ave Balto Date signed 7/2/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G53131 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 38 days
(e) Length of stay in Baltimore (yrs., mos., or days) 19 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and name town)
(d) Street No. 1111 Division Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Caeser (Rosa Anna Caeser)
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race Black
6 (a) ~~Single~~, married, ~~widowed, or divorced~~ M.
6 (b) Name of husband or wife ?
6 (c) If alive, give age ? years
7. Birth date of deceased (mo., day, yr.) 12-3-69
8. AGE: Years 77 Months 6 Days 26 If less than one day — hr. — min.
9. Birthplace S. C. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business
FATHER 12. Name Frank Wilson
13. Birthplace S.C.
MOTHER 14. Maiden Name Emma Wilson
15. Birthplace S.C.
16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Interment (Burial, cremation, or removal) (b) Date thereof 7/3/47 (month) (day) (year)
(c) Cemetery or crematory Lutherville, Md.
Location
18 (a) Funeral director Peter F. Mowen
(b) Address 1262 N. Caroline St
19 (a) Filed 7-3-1947 (b) Signature of Registrar Williamina Mott Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-29-1947, at 7.40 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 5-22-47 to 6-29-1947, and that I last saw her alive on 6-29-1947.
Immediate cause of death Cerebral Thrombosis — Duration 3 da.
Due to
Due to
Other Conditions Carcinoma of sigmoid & (Include pregnancy within 3 months of death)
Date of operation 6/6/47
Major findings of operation: Carcinoma of sigmoid & sigmoid
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Henry L. Bahnson
Address J.H.H. Date signed 6/30/47

VS 150

8310

C53132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C53132

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3525 Keswick Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3525 Keswick Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas J. Summers

3 (b) If veteran, name war: W
3 (c) Social Security Account No. 1

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: A. Virginia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 21 1861

8. AGE: Years 85 | Months 7 | Days 11 | If less than one day hr. min.

9. Birthplace Frederick Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Theodore Summers

13. Birthplace Washington

MOTHER 14. Maiden Name Rachel Hyde

15. Birthplace Maryland

16 (a) Informant A. Virginia Summers

(b) Address 3525 Keswick Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/3/47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore Md

18 (a) Funeral director Milton C. Rose

Address 1611 Pennsylvania Ave

19 (a) JUL 3 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1947, at P M

21. I certify that death occurred on the date above stated, that I attended deceased from July 2 1947 to July 2 1947 and that I last saw h[illegible] alive on 7-2-47 1947.

Immediate cause of death: Coronary Thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward A. Tarman M. D.

Address 9227 Falls Rd Date signed 7/2/47

Subject to approval by Medical Examiner. Ewd L Tarman

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53133

LN 111662

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

95 ✓

Registered No. G53133

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospital 25-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 72 yrs.

2. USUAL RESIDENCE OF DECEASED: Md. Ora
(a) State ~~Md.~~ (b) County
(c) City or town ~~Chesaco Park~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 608 Patapsco Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Plumhoff, Henry Gottreib

3 (b) If veteran, name war —

3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Louise (nee Diedeman)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14-1872

8. AGE: Years	Months	Days	If less than one day
74	10 11	18	hr. min.

9. Birthplace Washington, D.C.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Henry G. Plumhoff
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth King
15. Birthplace Pa.

16 (a) Informant Records Balto. City Hospital
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/5/47 (month) (day) (year)
(c) Cemetery or crematory St. Matthews
Location O'Donnell St.

18 (a) Funeral director John G. Connelly
(b) Address 3[illegible] Bank St. Balto. (Town, county, and state)

JUL 3 1947 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-1 1947, at 10:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 25- 1947 to July 1 1947, and that I last saw him alive on July 1 1947.

Immediate cause of death	Duration
Generalized arteriosclerosis	indefinite
Due to age	
Due to	
Other Conditions cardiac hypertrophy & congestion of viscera	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: see above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph J Bowen Jr M.D.
Address Balto. City Hospital Date signed 7-7-47

×

G53134

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G53134

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Parkway & 31st St.
(c) Hospital or institution:
U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 da
(e) Length of stay in Baltimore (yrs., mos., or days) 61 yrs.

6-2

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 113 N Rose St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME COLLIGAN, Elizabeth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Joseph Colligan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-9-85 1885

8. AGE: Years	Months	Days	If less than one day
61	7	23	hr. min.

9. Birthplace Maryland (Baltimore)
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own home

FATHER
12. Name Simon Hildebrand
13. Birthplace Germany

MOTHER
14. Maiden Name ~~Kitzbrant~~ Elizabeth Stein
15. Birthplace Baltimore, Md.

16 (a) Informant Patient
(b) Address

17 (a) Burial (b) Date thereof July 3
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mongold Park
Location Rural
18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St
19 JUL 3 1947 (b) Huntington Williams, M.D.
(Date rec'd by Reg.)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2, 1947 at 6:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 24 1947, to July 2 1947, and that I last saw h er alive on July 2 1947

Immediate cause of death Thrombus, aortic bifurcation — Duration

Due to Arteriosclerosis, general

Due to Coronary sclerosis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Glen E. Ogden
Glen E. Ogden M. D.
Address U.S. Marine Hosp. Date signed 7-2-47

X

G53135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G53135

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1406 Lindern Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltemore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1406 Linden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Washburn Bessee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Sarah Rebecca Bessee

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1 at 1880

8. AGE: Years	Months	Days	If less than one day
67	3		hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name Daniel Washburn Bessee
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Alice Virginia Morgan
15. Birthplace Balto. Md.

16 (a) Informant Sarah Rebecca Bessee
(b) Address 1406 Lindern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof 7/4/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Balto. Md.

18 (a) Funeral director Wilbur W. Stevens Inc
(b) Address 4130 Edmondson Ave.

19 (Date rec'd by registrar) JUL 3 1947 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1947, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1940 to June 30 1947, and that I last saw him alive on June 14 1947.

Immediate cause of death: Coronary Cardiovascular disease — Duration 6 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Emmett R. Cahn M. D.

Address 730 Park Ave Date signed 7/2/47

G53136 GRAMMER

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH .132

G53136 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3110 E. Monument St.
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3110 E. Monument (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carroll Grammer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-15-20

8. AGE: Years 27 | Months 2 | Days 17 | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Franklin Grammer
13. Birthplace Md.

MOTHER 14. Maiden Name Violet Tagg
15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 7/5/47 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Taylor Ave.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Road

19 (a) JUL 3 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1947 at 12 P 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 22 1947 to July 2 1947 and that I last saw h[illegible] alive on July 2 1947.

Immediate cause of death: Extensive pulmonary tuberculosis — Duration: 3 mos.
Due to
Due to
Other Conditions Diabetes Mel — 12 years
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas E. Van Metre Jr M. D.
Address John Hopkins Hosp Date signed 7/2/47

VS 150

X

G53137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G53137

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LAFAYETTE AND JOHN
(c) Hospital or institution: WOMEN'S HOSPITAL 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 85 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND County —
(b) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. CHARLES & MT VERNON PL WASHINGTON APTS (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME MAGGIE — HOOPER

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) MAR 23, 1862

8. AGE: Years	Months	Days	If less than one day
85	3	9	hr. min.

9. Birthplace BALTIMORE — MARYLAND (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business —

FATHER
12. Name THEODORE HOOPER
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name MARGARET MCWILLIAMS
15. Birthplace BALTIMORE MD

16 (a) Informant MISS FLORENCE HOOPER
(b) Address 101 E REDWOOD ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 5 1947 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md

18 (a) Funeral director Henry W. Deukins & Sons
(b) Address McCulloh & Orchard Sts.

19 (a) Filed July 1947 (b) Recorded by Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 July 1947, at 4:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 23 June 1947, to 2 July 1947 and that I last saw her alive on 2 July 1947.

Immediate cause of death	Duration
CARDIO RESPIRATORY FAILURE	
Due to CARDIAC FAILURE	12 HRS
Due to ARTERIO SCLEROTIC HEART DISEASE	
Other Conditions PARKINSON'S SYNDROME	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jules B Eyler Jr M.D.
Address Woman's Hospital Date signed 2 July 47 M. D.

X

G53138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G53138 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1138 Washington Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21-2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1138 Washington Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William J. Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Amelia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 14 1903

8. AGE: Years 43 | Months 9 | Days 18 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Molder & Buffer

11. Industry or business Westinghouse

FATHER
12. Name William J Thompson
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary V. Lewis
15. Birthplace Baltimore Md

16 (a) Informant Mr. William J Thompson
(b) Address 1138 Washington Blvd

17 (a) Funeral (Burial, cremation, or removal) (b) Date thereof 7 7 47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem
Location 4430 Belair Rd.

18 (a) Funeral director John D. Cowen & Son
(b) Address 903 W Fayette St

19 JUL 3 1947 (Date rec'd by registrar) (b) Huntington Williams, MD Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1947, at 2:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 1946 to July 2 1947, and that I last saw him alive on July 1 1947.

Immediate cause of death: Pulmonary Tuberculosis — Duration: 1 1/2 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John P. Ulrich, Jr

Address 1227 Wash. Blvd Date signed 7/2/47 M. D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53139 #B41155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

72a

Registered No. G53139

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens + Caton Aves.
(c) Hospital or institution: St. Agnes' Hospital 19-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1334 Hollins St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Richard R. Pleasant

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	W	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 1- 1946

8. AGE: Years	Months	Days	If less than one day
1	5	1	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Emmett R. Pleasant
13. Birthplace Cincinnati Ohio

MOTHER
14. Maiden Name Margaret Sagle
15. Birthplace Md.

16 (a) Informant Emmett R. Pleasant
(b) Address 1334 Hollins St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 4- 1947 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Balto Co Md

18 (a) Funeral director Pratt & B. M. Walter
(b) Address Pratt & Stricker Sts

19 JUL 3 1947 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1947, at 3:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/28 1947, to 7/2 1947, and that I last saw him alive on July 2 1947.

Immediate cause of death	Duration
Cerebral Embolism	
Thrombosis Coronary	
Due to Pneumonia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. W. Hunter M.D.
Address 1 Bryan Pl. Date signed 7/2/47 M. D.

G53140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

G53140 Registered No.

Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 15-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Dead

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 604 Cumberland St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~CHARLES~~ JOSEPH A GRAY

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1905

8. AGE: Years	Months	Days	If less than one day
42	1	9	hr. min.

9. Birthplace Oakville St. Mary's Co. Md.
(Town, county, and state)
10. Usual Occupation laborer
11. Industry or business

FATHER
12. Name Tom Gray
13. Birthplace St. Mary's Co. Md.

MOTHER
14. Maiden Name Jane Woodland
15. Birthplace St. Mary's Co. Md.

16 (a) Informant Mrs. Sam. Bankemp
(b) Address Mechanicsville Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 5, 1947 (month) (day) (year)
(c) Cemetery or crematory St. Josephs
Location Morganza Md.

18 (a) Funeral director W. B. Keating Leonardtown Md.
(b) Address Leonardtown Md.

19 (a) JUL 3 1947 (Date rec'd by local registrar) (b) Huntington Williams Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2, 1947, at 8.10 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertrophy of Heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L Ryon M.D.
Medical Examiner
Date signed 7-2-47

X

G53141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G53141

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1301 Park Ave.
(c) Hospital or institution:
convalescent home 14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1739 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Paula Owens

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Robt. E. T. Owens
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1879

8. AGE: Years	Months	Days	If less than one day
67	11	5	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name August Heller
13. Birthplace Austria

MOTHER
14. Maiden Name Lena Rosenthal
15. Birthplace Pa.

16 (a) Informant Miss Carlotta Heller
(b) Address 1739 Eutaw Place

17 (a) Burial (b) Date thereof 7/7/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~crematory~~ Har Sinai
Location Baltimore, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1950 Eutaw Place, Baltimore, Md.

19 JUL 3 1947 (b) Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1942, to July 3 1947, and that I last saw h alive on July 2 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to Metastatic cancer originating at left breast	1939
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 1939
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert B. Taylor M.D.
Address 104 W. Madison St. Date signed 7-3-47

G53142

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

4/132a ✓ G53142 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp 3-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 913 Fawn St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gregory Mugavero GREGORIO MUGAVERO

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-20-4753

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Salvatora

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14 1877

8. AGE: Years 69 70 | Months 6 8 | Days 1 18 | If less than one day hr. min.

9. Birthplace Sicily Italy (Town, county, and state)

10. Usual Occupation Baker

11. Industry or business Bread

FATHER
12. Name Onofrio Mugavero
13. Birthplace Italy

MOTHER
14. Maiden Name Concetta Brocato
15. Birthplace Italy

16 (a) Informant Son Paul Mugavero Baker
(b) Address 18 N. Hilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 5 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Rd., At Moravia Aye.

18 (a) Funeral director Frank Della Vaze
(b) Address 52 N. Morley St.

19 Jul 3 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-1- 1947, at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-23 1947 to 7-1 1947, and that I last saw h[illegible] alive on 7-1 1947

Immediate cause of death Uremia — Duration
p
Due to pyelonephritis
Due to
Other Conditions Cooley's Anemia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Elliott S. Wechsler M.D. M. D.
Address Sinai Hosp Date signed

X

G53143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G53143
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Johns Hopkins Hospital 6 E
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 12 N. Streeper St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Donohue (or) Donahue

3 (b) If veteran, name war: Spanish-American
3 (c) Social Security Account No.: none

4. Sex: M
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Elizabeth
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) June 4, 1878

8. AGE: Years 69 | Months — | Days 27 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation longshoreman
11. Industry or business Local # 829

FATHER
12. Name James Donohue
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary ?
15. Birthplace Ireland

16 (a) Informant Elizabeth Donohue
(b) Address 12 N. Streeper St.

17 (a) burial (b) Date thereof 7/4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Richie Highway

18 (a) Funeral director W. W. E. Dippel's Sons
(b) Address Lombard & Hanover Sts.

19 (a) JUL 3 1947 (Date received by registrar) (b) Huntington Wills Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1st 1947, at 12 A.M. 65 7/5

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Respiratory failure

Due to DOE

Other Conditions Arteriosclerotic cardiovascular disease over
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-1-47 at 12 A. M.
(b) Where did injury occur? G.H.H.
(c) Did injury occur at home, on farm, industrial place, in public place? Hospital While at work? no
(d) Means of injury During the administration of anesthetic

23. Signature Earl L. Young M.D.
Medical Examiner.
Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53144

G53144

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G53144
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 802 Belgian Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 802 Belgian Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES ELMER MAULER

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 213-10-7939

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Virginia C. Mauler

6 (c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): April 3, 1892

8. AGE: Years: 55 | Months: 3 | Days: 26 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: Salesman

11. Industry or business: Harry B. Cann Bros, Co.

FATHER
12. Name: Conrad Mauler
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Emma V. Mauler
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Mrs. Virginia C. Mauler - widow
(b) Address: 802 Belgian Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/3/47 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) Date received 1947 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 29 1947, to June 29 1947, and that I last saw h. alive on — 19—.

Immediate cause of death	Duration
Coronary occlusion	
Acute Coronary insufficiency	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W H Townsend Jr. M. D.
Address 1 E Lexington St Date signed 7/8/47

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 150 This patient had a Cardiac patient of Dr. C E Leach and I saw him today to assume for the city.

X

G53145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G53145 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write to the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1636 Monument St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No 1636 Monument St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie Murray Couch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 52 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name unknown
13. Birthplace " "

MOTHER
14. Maiden Name unknown
15. Birthplace " "

16 (a) Informant Mary Scott
(b) Address 1636 monument St

17 (a) Burial (b) Date thereof July 3, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md

18 (a) Funeral director Chas O. Wilson
(b) Address 1010 Reedbird ave

19 (a) (b) Huntington Williams M.D.
(Local registrar) (Registrar)

JUL 3 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1947, at 9 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1947, to June 30 1947, and that I last saw her alive on June 29 1947.

Immediate cause of death	Duration
Cerebral Accident	28 days
Due to Hypertension	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. W. McDaniel M. D.
Address 807 N. Caroline St Date signed 7-3-47

X

G53146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1467

Registered No. G53146

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 712 Cathedral St. (If rural give location)
(e) Citizen of foreign country? Na (Yes or No)
If yes, name country

3 (a) FULL NAME Frank J McDonough

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Madeline Mc Donough

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2, 1888

8. AGE: Years 59 | Months 4 | Days 9 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Encyclopedia Britannica

FATHER
12. Name James Mc Donough
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Clarke
15. Birthplace Pennsylvania

16 (a) Informant Mrs. Madeleine O. McDonough
(b) Address 3404 Windsor Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/5/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ New Cathedral
Location Baltimore Md

18 (a) Funeral director A. H. Means and Son
(b) Address 805 N. Calvert St.

19 JUL 3 1947 (b) Huntington Williams, M.D. Registrar
Date filed by registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2, 1947, at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-23-47 to 7-2 1947, and that I last saw him alive on 7-2 1947.

Immediate cause of death Uremia
Pulmonary edema

Due to Carcinoma of the rectum + generalized

Due to metastasis

Other Conditions Carcinoma of the rectum
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Ca. Rectum

Duration
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank A. Faraone, M.D.
Address Mercy Hospital Date signed 7/4/47

X

G53147

BALTIMORE CITY HEALTH DEPARTMENT X
CERTIFICATE OF DEATH 46 B

Registered No. G53147

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Madison & Linden
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 46D
(e) Length of stay in Baltimore (yrs., mos., or days): 46D.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Va (b) County:
(c) City or town: Kilmarnock (If outside city or town limits, write RURAL and give town)
(d) Street No.: — (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME Mrs. Anna Kathryn Dohrman

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or ~~wife~~: Henry C
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 13, 1887

8. AGE: Years	Months	Days	If less than one day
60	1	19	hr. min.

9. Birthplace: Washington D. C. (Town, county, and state)
10. Usual Occupation: H. W.
11. Industry or business:

FATHER
12. Name: John Pitsenger
13. Birthplace: Md. Prince Georges Co.

MOTHER
14. Maiden Name: Anna Margaret Dewald
15. Birthplace: Md.

16 (a) Informant: Henry C Dohrman
(b) Address: 402 Dennison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 5 1947 (month) (day) (year)
(c) Cemetery or crematory: Meadowridge
Location: Dover Md

18 (a) Funeral director: Harry H Wilson
(b) Address: 416 Woodson Ave

19 JUL 3 1947 (Date rec'd by registrar) (b) Huntington Williams Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/2 1947, at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/15/ 1947, to 7/2 1947, and that I last saw h alive on 7/2 1947.

Immediate cause of death	Duration
Pneumatosis + Carcinoma of colon	
Due to Shrinkage cell CA of stomach, Post op gastric resection +	
Due to Intestinal fistula	
Due to Diabetes mellitus	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation: 5/29/47
Major findings of operation: Scirrhous cell CA of Stomach
of autopsy: - None -

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: A. Mitchell M.D.
Address: Jud. Gen Hosp Signed 7/2/47

X

C53148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

B 82371 / 159

Registered No. C53148

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County B. a. Co.
(c) City or town Glen Burnie
(If outside city or town limits, write RURAL and give town)
(d) Street No. 23 New Jersey
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Littleton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W. White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/1/47

8. AGE: Years	Months	Days	If less than one day
			12 hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Morgan A Littleton
13. Birthplace Balto Md

MOTHER
14. Maiden Name Margaret A Thomey
15. Birthplace Balto Md

16 (a) Informant Mr Morgan A Littleton
(b) Address 23 New Jersey Ave - Glenburnie

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof July 3 '47 (month) (day) (year)
(c) Cemetery or crematory Pine Hill
Location Old Frederick Rd

18 (a) Funeral director Harry H Wetzler
(b) Address 4101 Edmondson Ave

19 (a) JUL 3 1947 (Date rec'd by registrar) Huntington Williams (Address)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1947 at 11:42 PM 1:00 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death Prematurity

Due to Respiratory failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Asher Friedman M. D.
Address Date signed

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C53149 GM. 103517

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C53149

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE .
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 10 MO.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 411 N Pearl ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Johnson , Edward

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12 - 1924

8. AGE: Years 22 | Months 9 | Days 20 | If less than one day ... hr. ... min.

9. Birthplace S.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Johnson (D)
13. Birthplace S.C.

MOTHER
14. Maiden Name Mary (D)
15. Birthplace S.C.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-5-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director Thos. R. Jones
(b) Address 802 Madison Ave

19 (a) JUL 3 1947 (Date rec'd by registrar) (b) Interior for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July - 2 - 1947 at 1.00A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 6 - 1946 to July - 2 - 1947 and that I last saw h... alive on July - 2 - 1947.

Immediate cause of death: Pulmonary tuberculosis — Duration: two years

Due to

Due to

Other Conditions: Syphilis, Congenital Heart disease — Duration: seven years
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph J Bowen Jr M. D.
Address Balto City Hospitals Date signed 7-2-47

VS 150

1315

G53150

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1947

Registered No. G53150

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 4 1
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 330 St. Paul st. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Herbert B Coates

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 2-1883

8. AGE: Years 63 | Months 11 | Days 29 | If less than one day hr. min.

9. Birthplace Raleigh N.C. (Town, county, and state)

10. Usual Occupation Retired Merchant

11. Industry or business

FATHER
12. Name L W Coates
13. Birthplace Johnson Co. N.C.

MOTHER
14. Maiden Name Mary Poole
15. Birthplace Wilson Co N C

16 (a) Informant Mrs H B Brewer
(b) Address Raleigh N.C.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 7/3/47 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem
Location Balto Md

18 (a) Funeral director Geo L Bayer Jr
(b) Address 1512 Hollins St

JUL 3 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1, 1947 at 5 P. M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial degeneration.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L Bayer M.D. Medical Examiner

Date signed 7-2-47

PRINT WITH PENCIL, WRITE UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1176

G53151
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Lombard St
(c) Hospital or institution:
University Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto. 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3208 Beverly Rd
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME George N. Gundersdorf - Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. D.

6 (b) Name of husband or wife Mary E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 11-1895

8. AGE: Years 52 Months 3 Days 21/22 If less than one day hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name George E. Gundersdorf
13. Birthplace Md.

MOTHER
14. Maiden Name Agnes Clark
15. Birthplace Md.

16 (a) Informant Mr. George Gundersdorf
(b) Address 3106 Cedarhurst Rd.

17 (a) Burial (b) Date thereof 7-5-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Druid Ridge
Location Balto

18 (a) Funeral director Leonard J. Luck
(b) Address 5304 Harford Rd.

19 (a) JUL 3 1947 (b) Evelington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1947 at 3 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947 to July 2 1947, and that I last saw him alive on July 2 1947.

Immediate cause of death Respiratory obstruction, due to vomiting, due to acute dilation — Duration

Due to stomach, due to gastrostomy

Due to due to rupture peptic ulcer

Due to

Other Conditions mild diabetes,
(Include pregnancy within 3 months of death)

Date of operation 6/27/47

Major findings of operation: perforated duodenal ulcer

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard E. Dalle M. D.
Address University Hosp. Date signed 7-2-47

G53152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No. G53152

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1522
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2212 Baker St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME CATHERINE AMELIA HIRTH

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife "Webster Clay Hirth"
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 13, 1886

8. AGE: Years 61 | Months 0 | Days 19 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business .....

FATHER
12. Name Christian Heinz
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mr. Edward Hirth
(b) Address 919 N. Charles St.

17 (a) Burial (b) Date thereof 7/5/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUL 3 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1947 at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-30 1947 to 7-2-1947 and that I last saw her alive on 7-2-1947

Immediate cause of death	Duration
Pulmonary Edema.	
Due to Generalized Carcinomatosis	
Due to Primary site uterus	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work?
(Specify type of place)
(e) Means of injury .....

23. Signature E. Hirth M. D.
Address University Hosp. Date signed 7-2-47

Filing X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G53153

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4902 Roland Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4902 Roland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FLORENCE A. HORN

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: George K. Horn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1864

8. AGE: Years 83 | Months 4 | Days 25 | If less than one day: hr. min.

9. Birthplace Burlington, N. J.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Jonathan Maguire
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mr. Calvin C. Horn, son
(b) Address 406 Hollen Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/5/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUL 3 1947 (Date rec'd by registrar) (b) Huntington Hillcrest

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2, 1947 at 2:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 to July 2 1947, and that I last saw h— alive on July 1 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	3 days
Due to cerebral arteriosclerosis	15 yrs
Due to senility	15 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. J. Charlton M. D.
Address 6210 York Rd Date signed July 3 1947

G53154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G53154

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Lanvale Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1910 W. Saratoga St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN H. WHITE

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-05-4481

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary G. White

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2/10/1898

8. AGE: Years 49 | Months 48 | Days 21 | If less than one day ..... hr. ..... min.

9. Birthplace Celestin Md (Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business Gen Electric Co

FATHER — 12. Name Roman White

FATHER — 13. Birthplace Celestin, Md

MOTHER — 14. Maiden Name Jennie E. Winchester

MOTHER — 15. Birthplace Westminster, Md

16 (a) Informant Mary G. White

(b) Address 1910 W. Saratoga St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof July 4/47 (month) (day) (year)

(c) Cemetery or crematory Stevensville

Location Stevensville, Md

18 (a) Funeral director F. D. WEPPERT. SON

(b) Address 300 Eutaw Place

19 (a) JUL 3 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 19 47, at 7.52 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary thrombosis

Pulmonary edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ..... at ..... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.

Date signed 7/1/47

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G53155

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Frederick Ave
(c) Hospital or institution: Colonial Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Months
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2520 Arunsdale Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma D. Kendall

3 (b) If veteran, name war —
3 (c) Social Security Account No. 217-05-1904

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: C. C. Kendall
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 5 - 1888

8. AGE: Years 59 | Months 5 | Days 28 | If less than one day — hr. — min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Ferdinand Senger
13. Birthplace Germany

MOTHER
14. Maiden Name Emma Stidel
15. Birthplace Germany

16 (a) Informant Mrs Wm A. Norris
(b) Address 2520 Arunsdale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/6/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md

18 (a) Funeral director J. A. Pritchett & Son
(b) Address 1300 Eutaw Place

19 (a) JUL 5 1947 (Date rec'd by registrar) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 1947, at 9a M

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 1947, to July 3 1947, and that I last saw h— alive on July 2 1947.

Immediate cause of death	Duration
Pulmonary Oedema	
Due to Hypostatic Pneumonia	
Due to Arteriosclerosis	
Other Conditions Circumstantial of Senility	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert C Pritchett
Address 2151 Mulberry St Date signed 7/3/47
M. D.

X

G53156

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G53156 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2245 Prentice Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2245 Prentice Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel L. Pitchett

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Rose V. Pitchett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept-17-1863

8. AGE: Years	Months	Days	If less than one day
83	9	14	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name	James Pitchett
13. Birthplace	Fair Haven, Md
MOTHER 14. Maiden Name	Esau Bates Wheeler
15. Birthplace	Md

16 (a) Informant Mrs Grace Smith
(b) Address 2245 Prentice Place
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/3/47 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location North Ave.
18 (a) Funeral director John E. Miller Inc
(b) Address 2435 E. Oliver St
19 (a) 1947 Huddington Williams Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1947, at 8P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1947 to July 1 1947, and that I last saw him alive on July 1 1947.

Immediate cause of death	Duration
Cerebral apoplexy	10 days
Due to Cerebral arteriosclerosis ?	
& Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Mark Stanley M. D.
Address 200 E Pratt St Date signed 7/1/47

G53157

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46D

G53157 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 337 E Calvert
(c) Hospital or institution:
Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore 13
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2616 East Chase St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Martin J. O'Hern

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Mrs. Martin J. O'Hern
6 (c) If alive, give age alive years

7. Birth date of deceased (mo., day, yr.) April 12, 1871

8. AGE: Years	Months	Days	If less than one day
76	2	19	hr. min.

9. Birthplace Ireland
(Town, county, and state)
10. Usual Occupation retired army man
11. Industry or business

FATHER
12. Name Martin O'Hern
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Green
15. Birthplace Ireland

16 (a) Informant Mrs. Martin J. O'Hern
(b) Address 2616 E. Chase St.

17 (a) 7-5-47 (b) Date thereof Burial
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore National Cem.
Location Frederick Rd.

18 (a) Funeral director John C. Miller Inc.
(b) Address 2432 E Oliver St

19 (a) JUL 3 1947 (Date received by registrar) Huntington Whitehurst, Registrar

VS . 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1 1947, at 8:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 24 1947, to July 1 1947, and that I last saw him alive on July 1 1947.

Immediate cause of death	Duration
Toxemia due to intestinal obstruction	
Due to carcinoma of the rectum	
Due to	
Other Conditions mild cachexia, cardiac decompensation	

(Include pregnancy within 3 months of death)
Date of operation 6-24-47
Major findings of operation: carcinoma of the rectum & low intestinal obstruction
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. W. Johnson M. D.
Address Union Memorial Hosp. Date signed 7-1-47

X

G53158

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G53158

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2116 East Baltimore Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3110 East Baltimore St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Robert G. McComas

3 (b) If veteran, name war Indian 1878

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced:

6 (b) Name of husband or wife: Mary Klung

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) 11/16/1861

8. AGE: Years 85 | Months 7 | Days 18 | If less than one day: hr. X min. X

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Wm. McComas.
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Anne Lidell
15. Birthplace

16 (a) Informant William M. McComas Son
(b) Address 534 N. Robenson st

17 (a) Burial (b) Date thereof 7-5-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lorraine Caulk.
Location Baltimore Co. Md.

18 (a) Funeral director George J. Pulto Inc
(b) Address 1735 Hartford Ave

19 JUL 3 1947 Registrar for Williams, M.D.
(Date rec'd by Registrar)

VS 151

MEDICAL CERTIFICATION 50

20. DATE OF DEATH July 3, 1947 at 11a M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Thomas J. Mooney M.D.
Medical Examiner.
Date signed 7/3/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G53159 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1714 N. Calvert st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1714 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Elizabeth M. Haines

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) ~~Single, married~~, widowed, or divorced: Widowed

6 (b) Name of husband ~~or wife~~: George V. Haines
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 14th 1863

8. AGE: Years: 84 | Months: 4 | Days: 19 | If less than one day: hr. min.

9. Birthplace Howard Co. Ind.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Thomas R. Robertson
13. Birthplace Virginia

MOTHER
14. Maiden Name Emily Dilly
15. Birthplace Indiana

16 (a) Informant Clarence Haines
(b) Address 1714 N. Calvert St.

17 (a) Removal (b) Date thereof 7/4/47
(~~Burial, cremation,~~ or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Elwood
Location Indiana

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st

19 (a) (Date received by registrar) (b) Huntington Williams M.D. Registrar

JUL 4 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3rd 1947, at 6:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1945 to July 3 1947 and that I last saw h[illegible] alive on July 1 1947.

Immediate cause of death: Cardiac decompensation
Due to: arteriosclerosis
Due to: Carcinoma of pancreas
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at: M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jack J. Singer
Address 506 E. Hoffman Date signed 7-3-47

X

G53160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 93E

G53160 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 W Coldspring Lane
(c) Hospital or institution:
Coldspring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 439 Whitridge Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Hofmann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) ~~Single, married, widowed, or divorced~~ Married

6 (b) Name of husband ~~or wife~~ John S. Hofmann

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21st 1893

8. AGE: Years 54 | Months 3 | Days 12 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business Own Home

FATHER
12. Name William P. Connor
13. Birthplace Va.

MOTHER
14. Maiden Name Ella ?
15. Birthplace Md.

16 (a) Informant Evelyn Fisher
(b) Address 439 Whitridge Ave

17 (a) Burial (b) Date thereof 7/5/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3rd 1947, at 9 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1946 to July 2, 1947; and that I last saw her alive on July 2, 1947.

Immediate cause of death Myocardial insufficiency — Duration ?

Due to

Due to

Other Conditions General arteriosclerosis. — ?
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Willis Guyton M.D.
Address 3963 Greenmount Ave Date signed 7/3/47.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53161

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 937

Registered No. G53161

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~Number~~ 33 Calvert St.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6318 Sherwood Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Samuel J. Miles

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of ~~husband or~~ wife Lucy V. Miles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 2-6-87

8. AGE: Years	Months	Days	If less than one day
60	4	26	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Wine Merchant
11. Industry or business Self

FATHER
12. Name Samuel J. Miles
13. Birthplace Maryland.

MOTHER
14. Maiden Name Sara Katherine Hickey
15. Birthplace Maryland

16 (a) Informant Lucy V. Miles
(b) Address 6318 Sherwood Rd

17 (a) Burial (b) Date thereof 7/5/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Loudon Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (b) Clifton Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-2 1947 at 8:22 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-1 1947 to 7-2 1947 and that I last saw h ~~im~~ alive on 7-2 1947.

Immediate cause of death	Duration
Intestinal Hemorrhage	
Due to Undetermined Origin	
Due to	
Other Conditions Atherosclerotic Heart Disease	

(Include pregnancy within 3 months of death)

Date of operation 7-1-47
Major findings of operation: None
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry G Beckwith Jr.
Address Union Mem. Hosp. Date signed 7-2-47 M. D.

123

G53162 — Registered No. G53162

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring Ave
(c) Hospital or institution: Aged Home Lesindale

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. Belvedere Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROSE YAGER

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: FEMALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife SCHAFER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 65 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER 12. Name NOT KNOWN
13. Birthplace RUSSIA

MOTHER 14. Maiden Name NOT KNOWN
15. Birthplace RUSSIA

16 (a) Informant HOSP RECORDS
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-4-47 (month) (day) (year)
(c) Cemetery or crematory MT CARMEL
Location GERMAN HILL RD

18 (a) Funeral director Jos C Lewis Inc
(b) Address 1439 E. Balto St

19 (a) (Date received by registrar) Huntington Williams, MD Registrar

4 vs 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 1947, at 9.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-19 1947, to 7-3 1947, and that I last saw h alive on 7-3 1947.

Immediate cause of death Bron. Pneumonia
Cerebral Arteriosclerosis
Hypertension — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H Edmund Kevin

Address Lesindale Date signed 7/3/47

X

G53163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓106B

G53163

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address MADISON AVE
(c) Hospital or institution: TEMPLE GARDEN APTS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. MADISON AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ABRAHAM CUMMINS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife JENNIE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation RETIRED

11. Industry or business

FATHER
12. Name GEORGIA
13. Birthplace RUSSIA

MOTHER
14. Maiden Name CHANG
15. Birthplace RUSSIA

16 (a) Informant WIFE
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7-4-47 (month) (day) (year)
(c) Cemetery or crematory Bikur Cholim Cemetery
Location ~~Forest Ave~~ Southern Ave

18 (a) Funeral director JACK LEWIS INC
(b) Address 1400 EUTAW PL.

19 (a) 1947 (Date rec'd by registrar) (b) Funeral for William Cummins

V8 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-3-1947, at 1 04 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/5 1946 to 6/3 1947 and that I last saw h alive on 7/3 1947

Immediate cause of death Cardiac Insufficiency

Due to Hypertension Arteriosclerosis

Due to Sen Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
1.
2
3
4
5.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Lamm

Address 1261 E North Ave Date signed 7/3/47 M. D.

G53164 B44 B-36273

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 786

G53164
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1223 McCulloh St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dwight Kinard

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-5-45

8. AGE: Years 1 | Months 7 | Days 27 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Clarence Roy
13. Birthplace Md

MOTHER 14. Maiden Name Elizabeth Kinard
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-5-47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore, Md

18 (a) Funeral director M.D. Francis H. Flanagan
(b) Address 572 W. Biddle St

19 (a) (Date rec'd by registrar) (b) Registrar

1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2, 1947, at 9:31 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 28 1947 to July 2 1947 and that I last saw him alive on July 2 1947.

Immediate cause of death: Lead Poisoning, acute — Duration: 10 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accidental ingestion of paint chips
(b) Date of occurrence One month prior to death M
(c) Where did injury occur? Balto (City or town) Balto (County) Md (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work?
(e) Means of injury Lead poisoning, see text 22a

23. Signature Philip Brown M. D.
Address Johns Hopkins Hosp Date signed 7-2-47

G53165 FL - 111776

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G53165 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 511 S. Patterson Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Shanoski (or) Franciszka Shanowska (Koslowska)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife John
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1902

8. AGE: Years	Months	Days	If less than one day
45	3	16	hr. min.

9. Birthplace Penna. - Mt. Carmel
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name ? Thomas Petruszewicz
13. Birthplace Poland

MOTHER
14. Maiden Name ? Elizabeth ?
15. Birthplace Poland

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 7/4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location German Hill Rd.

18 (a) Funeral director M. W. E. Pippelli Sons
(b) Address 1800 E. Lombard St.

19 (a) 1947 (b) Huntington Williams M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1, 1947, at 5.25P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 28 1947 to July 1 1947, and that I last saw h. er alive on July 1 1947.

Immediate cause of death	Duration
Glomerulonephritis Chronic	1 yr.
Due to Hypertensive Cardiovascular Disease with cardiac hypertrophy & pulmonary	?
Other Conditions Edema	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hosp. Date signed 7-4-47

X

G53166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G53166 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2510 E. Biddle St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2510 E. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Augusta D. Richardson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Frank O. Richardson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct. 15 1861

8. AGE: Years 85 | Months 8 | Days 17 | If less than one day hr. min.

9. Birthplace Talbot Co. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas Lowe
13. Birthplace Talbot Co Md.

MOTHER
14. Maiden Name Anna Pintel
15. Birthplace Talbot Co Md.

16 (a) Informant Frank O. Richardson
(b) Address 2510 E. Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 5/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director John. J. Hyson
(b) Address 3000 E. Balto. St.

19 (a) JUL 4 1947 (Date received by registrar) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to July 1 1947 and that I last saw h[illegible] alive on July 2 1947.

	Duration
Immediate cause of death: Uremia	24 hrs
Due to Hypertensive Cardio Vascular Renal Disease	10 yrs.
Due to Arteriosclerosis	20 yrs.
Other Conditions Chronic Myocarditis	10 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank D. Trigilio M. D.

Address 1011 N Charles St Date signed 7/3/47

G53167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G53167
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3008 Oakley Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3008 Oakley Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Shaina Kaufman

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Tava
13. Birthplace Russia

MOTHER
14. Maiden Name Leah
15. Birthplace Russia

16 (a) Informant Mrs Anna Kaufman
(b) Address 3008 Oakley Ave

17 (a) Burial (b) Date thereof 7-4-47
(Burial, cremation or removal) (month) (day) (year)
(c) Cemetery or crematory Randall
Location Pulaski Rd
18 (a) Funeral director Funk Lewis Inc.
(b) Address

19 (a) JUL 4 1947 (Date received by registrar) Washington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-4-47 19 at 7 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 11 1946 to July 4 1947 and that I last saw her alive on 7-4 1947.

Immediate cause of death Coronary Thrombosis — Duration 2 yrs
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H R Johnson M. D.
Address 403 Medical Bldg Date signed 7-7-47

G53168 G53168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 141B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette
(c) Hospital or institution: Franklin Square
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3900 Brookhill Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME MINERVA REICHER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Sidney S. Reicher
6 (c) If dead, give age years

7. Birth date of deceased (mo., day, yr.) Nov 29, 1921

8. AGE: Years	Months	Days	If less than one day
25	7	4	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Nathan Barden
13. Birthplace Md

MOTHER
14. Maiden Name Sophie Jacobs
15. Birthplace Md

16 (a) Informant Sidney S. Reicher
(b) Address 3900 Brookhill Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-6-47 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Rogers Ave

18 (a) Funeral director Jack C. Jenkins Inc
(b) Address 4432 E. Baltimore St

19 (a) 1947 (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-3 1947, at 6:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1947 to 7/3 1947 and that I last saw her alive on 7/3 1947.

Immediate cause of death Post operative shock — Duration

Due to Embolus?

Due to Anesthesia?

Other Conditions Incomplete abortion
(Include pregnancy within 3 months of death)

Date of operation 7/3/47

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard J. Moseley, M.D.
Address 6 E. Mt. Vernon Pl. Date signed 7/3/47

G53169

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 837

G53169
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 751 Granby St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) [redacted]
(e) Length of stay in Baltimore (yrs., mos., or days) 6 dys.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. Co.
(c) City or town Halethorpe
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2104 Pine Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Edward Keith Smith

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Lillian M. Baker

6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) June 12-1882

8. AGE: Years 65 | Months 0 | Days 16 | If less than one day ... hr. ... min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Edward Smith
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden Name Adaline Barnes
15. Birthplace Carroll Co. Md.

16 (a) Informant Lillian M. Smith
(b) Address 2104 Pine Ave Halethorpe, Md.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof July 6-47 (month) (day) (year)
(c) Cemetery or crematory Linganore Cem.
Location Unionville, Md.

18 (a) Funeral director H. Bankard Sons
(b) Address Westminster, Md.

19 JUL 5 - 1947 (Date) (b) [redacted] (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1947 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to July 4 1947 and that I last saw h[redacted] alive on July 3 1947

Immediate cause of death ... Duration

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ira E. Mentzell M.D.
Address 236 E. Main St. Date signed 7/4/47

X

G53170

BALTIMORE CITY HEALTH DEPARTMENT

BC# 382526 CERTIFICATE OF DEATH 157E

Registered No. G53170

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address .....

(c) Hospital or institution: University Hosp. Sowland & Greene

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Anne Arundel

(c) City or town Baltimore, 1.
(If outside city or town limits, write RURAL and give town)

(d) Street No. Sowland & Greene Sts. 5251 WASENA AVE (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME Baby Boy Coldbeck (Edward Alfred Coldbeck II)

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex male

5. Color or race white

6 (a) (Single), married, widowed, or divorced.

6 (b) Name of husband or wife None

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 1, 1947

8. AGE: Years ..... Months ..... Days 2 If less than one day ..... hr. ..... min.

9. Birthplace Baltimore MD.
(Town, county, and state)

10. Usual Occupation Baby

11. Industry or business .....

FATHER 12. Name Edward A. Coldbeck

13. Birthplace Maryland

MOTHER 14. Maiden Name Mary E. Marshall

15. Birthplace Maryland

16 (a) Informant Edward A. Coldbeck

(b) Address 5251 Wasena Ave.

17 (a) Burial (b) Date thereof 7-5-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore, Maryland

18 (a) Funeral director George L. Schaub

(b) Address 2101 Hilldrick Ave.

19 JUL 5 - 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/3/47 1947, at 5:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/3/47 to 7/3/47, and that I last saw him alive on 7/3 1947.

Immediate cause of death Asphyxia — Duration .....

Due to Congenital Heart Disease. — Duration .....

Due to ..... — Duration .....

Other Conditions ..... — Duration .....

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: .....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? ..... (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)

(e) Means of injury .....

23. Signature H. B. Huntington, M.D.

Address Univ. Hospital Date signed 7/4/47

X

Birth Certificate

G53171 G-82993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registration No. G53171

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 71
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 755 Ramsay St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mildred Gladfelter

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓
Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife ✓
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 7-1-47
8. AGE: Years — Months — Days 1 If less than one day — hr. — min.
9. Birthplace Md. Baltimore
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name James Andrew Gladfelter
13. Birthplace Pa.

MOTHER
14. Maiden Name Amelia Latini
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 7/5/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director John F. Cowan & Son
(b) Address 901-03 N. Collins St.

19 (a) 7-5-1947 Huntington Williams, M.D.
(Signature of registrar) (Address)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-3-1947 at 10:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-2-1947 to 7-3-1947
and that I last saw her alive on 7-3 1947

Immediate cause of death	Duration
Prematurity	1 day
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature J. M. Edmunds
Address Johns Hopkins Date signed 7-7-47 M. D.

X

Birth Certificate
G53172 G. 82237

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

Registered No. G53172

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Centre Sts
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 4 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 211 S. Register St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Villa

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ~~7-4-00~~ 7-4-47

8. AGE: Years	Months	Days	If less than one day
			4 hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Paul Villa
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Amelia Behrens
15. Birthplace Balto. Md.

16 (a) Informant Records
(b) Address Mercy Hospital

17 (a) Burial (b) Date thereof 7/5/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) JUL 5 - 1947 Huntington Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-4 1947, at 9:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-4 1947 to 7-4 1947 and that I last saw h[illegible] alive on 7-4 1947.

Immediate cause of death Pulmonary atelectasis
Premature infant.

Duration
4 hrs.

Due to

Due to

Other Conditions Congenital

(Include pregnancy within 3 months of death)
Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William D. Leahy M.D.
Address Mercy Hosp Date signed 7-9-47

X

C53173

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

57 D

Registered No. C53173

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 252 S. East Ave.
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ~~Balto~~
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 252 S. East. Ave. (If rural give location)
(e) Citizen of foreign country? Md. (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Dippel
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or ~~wife~~: John M. Dippel
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 20, 1906
8. AGE: Years 41 Months 4 Days 10 If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Meinecke
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary Feichman
15. Birthplace Baltimore, Md.

16 (a) Informant Louie Dippel
(b) Address 252 S. East ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 7 47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore

18 (a) Funeral director Philip Herring Sons
(b) Address 1024 Orleans St.

19 (a) JUL 5 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1947, at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947, to July 7 1947, and that I last saw her alive on July 7 1947.

Immediate cause of death: Brain Tumor — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph D'Antoni M.D.
Address Church Home & Hosp. Date signed 7/7/47

X

G53174

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. G53174

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2075 Rockrose Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 80yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 402 N. Clinton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman J. Stahm

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Barbara Stahm
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1863

8. AGE: Years	Months	Days	If less than one day
84	0	17	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name ----Stahm
13. Birthplace Germany

MOTHER
14. Maiden Name Johanna ---
15. Birthplace Germany

16 (a) Informant Mr. J. Hessenauer
(b) Address 4301 Walther Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 5/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto. Md.

18 (a) Funeral director Philip Stuwig Sons
(b) Address 2024 Orleans St.

19 (a) JUL 5 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3/47 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 2 1947 to July 3 1947 and that I last saw h[illegible] alive on July 3 1947.

Immediate cause of death

Duration

Carcinoma of Stomach 7

Due to

Due to

Other Conditions
Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Glassman M. D.
Address 26 P Medical Arts Date signed July 23-47

X

G53175 42225 BALTIMORE CITY HEALTH DEPARTMENT G53175

CERTIFICATE OF DEATH 46F

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2410 Overland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Leonard Wheatley

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Margaret

6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) 9-18-98

8. AGE: Years 48 | Months 9 | Days 15 | If less than one day hr. min.

9. Birthplace Texas (Town, county, and state)

10. Usual Occupation Social Worker

11. Industry or business

FATHER 12. Name Leonard Wheatley

13. Birthplace Texas

MOTHER 14. Maiden Name Ida Hanna

15. Birthplace Texas

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/8/47 (month) (day) (year)

(c) Cemetery or crematory Mineral Wells, Texas

Location Mineral Wells, Texas

18 (a) Funeral director William J. Chatman Jr

(b) Address 1701 McCulloh St.

19 JUL 5 - 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3, 1947 at 3:37 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 26 1947 to July 3 1947 and that I last saw h[illegible] alive on July 3 1947.

Immediate cause of death: Cardiac and Respiratory Failure — Duration:

Due to: Nodular cirrhosis with Primary Giant cell carcinoma — 3 mo.

Due to:

Other Conditions: Pulmonary tuberculosis - Old

(Include pregnancy within 3 months of death)

Date of operation 13 June 1947

Major findings of operations: nodular

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature J. H. Gisson

Address Johns Hopkins Hosp. Date signed 3 July 47 M. D.

VS 150

C53176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. C53176

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5806 Park Heights Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Rice

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	W.

6 (b) Name of husband or wife Estelle Jewell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 10, 1867

8. AGE: Years	Months	Days	If less than one day
80	5	22	hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name —
13. Birthplace

MOTHER
14. Maiden Name —
15. Birthplace

16 (a) Informant Family
(b) Address 5806 Park Heights Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof 7-5-47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Co. Md.

18 (a) Funeral director James L. McCauley
(b) Address 134 E. Fort Ave.

19 (a) Filed JUL 5 1947 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 July 1947, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 29, 1947 to 2 July 1947, and that I last saw him alive on 2 July 1947.

Immediate cause of death	Duration
Pneumonia	
Due to decubitus ulcers & wound infection	
Due to	
Other Conditions Arteriosclerotic cardio-vasc. disease. Fract. r. femur	

(Include pregnancy within 3 months of death)

Date of operation 22 May 1947

Major findings of operation: Fract. shaft right femur

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 5-29-47 at a M
(c) Where did injury occur 5306 Park Heights Ave Balto Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Fell at home

23. Signature M. Shapiro, M.D.
Address Sinai Hosp. Date signed 2 July '47
For Stillborn: Delivered by , M.D.

G53177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G53177

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1928 Brunt St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 1928 Brunt St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Arlean E. Dudley

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Jennie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 28, 1896

8. AGE: Years 50 | Months 6 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore Co. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Daniel Scott
13. Birthplace Richmond, Va.

MOTHER
14. Maiden Name Jane Causeaway
15. Birthplace Maryland

16 (a) Informant Amelia Marshall
(b) Address 1909 McKean Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 5, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Jas. Lee A. Holland
(b) Address 1631 Druid Hill Ave.

19 (Date received by registrar) JUL 5 - 1947 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1947, at 8:07 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-31 1947, to 7-7 1947, and that I last saw h[illegible] alive on 6-3-2 19[illegible].

Immediate cause of death: Myocarditis

Due to:

Due to:

Other Conditions: Diabetes mellitus — poly arthritis
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration
Unknown
Unknown

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Francis A. Saunders M. D.
Address 1029 N. Stricker Date signed 7-7-47

93E

G53178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

CM. 110811

61

Registered No. G53178

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 9 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2126 Etting ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dale, Helen Hortense

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Harry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May -14 -1883

8. AGE: Years	Months	Days	If less than one day
64	1	16	hr. min.

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph Pinkney
13. Birthplace MD.

MOTHER 14. Maiden Name Sarah Nelson
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 5, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Baltimore, Md.

18 (a) Funeral director J. Purston Lindsay
(b) Address 5 E. Baker St.

19 (a) JUL 5 - 1947 (Date rec'd by registrar) Huntington Willis, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 - 1947, at 1030 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May -21 1947, to June 30 1947, and that I last saw her alive on June 30 - 1947.

Immediate cause of death	Duration
Gangrene	
Pulmonary Embolism	
Due to Hypertensive-Cardio-Vascular Arteriosclerotic Disease	
Due to Diabetic Gangrene of left thigh	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 5/27/47
Major findings of operation: Gangrene, left leg.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. L. Konos
Address Baltimore City Hosp. Date signed 7/1/47 (M) (D)

X

G53179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G53179

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 410 S. Paca St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 410 S. Paca
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Franklin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	married

6 (b) Name of husband or wife Eustace Franklin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 6, 1896

8. AGE: Years	Months	Days	If less than one day
50	10	27	hr. min.

9. Birthplace Raleigh, N C.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Johnson
13. Birthplace Raleigh N.C.

MOTHER
14. Maiden Name Eliza Ramsay
15. Birthplace Raleigh N.C.

16 (a) Informant Ora Colbert
(b) Address 410 S. Paca St.

17 (a) Burial (b) Date thereof 7-5-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 222 N. Schroeder St

19 (a) JUL 5 - 1947 Huntington Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/2/47 19 , at 7 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/24/47 19 7/2/47, and that I last saw her alive on 6/29/47.

Immediate cause of death Pneumonia
Contributory

Due to Coronary Artery Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration 3 Days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. C. Ellis M. D.
Address [illegible] Date signed 7-7-47

VS 150

G53180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

Registered No. G53180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1439 Mt. Royal Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1439 Mt. Royal Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY JOSEPH HEYER

3 (b) If veteran, name war: none
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: –
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1, 1880

8. AGE: Years 66 | Months 11 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Floorman

11. Industry or business

FATHER
12. Name Frederick R. Heyer
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina Bitter
15. Birthplace Germany

16 (a) Informant Mrs. F. N. Heyer
(b) Address 4019 Dorchester Rd.

17 (a) Burial (b) Date thereof 7/7/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUL 5 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar (b) Address

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3, 1947 at 10:30 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 to July 3 1947.
and that I last saw h alive on July 2, 1947

Immediate cause of death	Duration
Cardiac decompensation	7 days
Due to Chr. myocarditis and Hypertension, accelerated	
Due to Uremia, pyelonephritis, nephrolithiasis and general arteriosclerosis	5 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. N. Heyer M. D.
Address 115 E Eager Date signed 7/7/47

G53181

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G53181 Registered No.

Every item of information should be careful... supplied. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1305 N. Fulton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1305 N. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Santi J. Cianci

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Salvatora Cianci (nee Tamburo) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1873

8. AGE: Years	Months	Days	If less than one day
74	6	3	hr. min.

9. Birthplace Italy
(Town, county, and state)
10. Usual Occupation Fruit Vendor
11. Industry or business Self

FATHER
12. Name Joseph Cianci
13. Birthplace Sicily, Italy

MOTHER
14. Maiden Name Francisca Figgota
15. Birthplace Italy

16 (a) Informant Mr. Francis Cianci
(b) Address 1912 Ridgehill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/9/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUL 5 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1947, at 11:01 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Renal

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Kefauver M.D.
Medical Examiner.
Date signed July 4, 1947

G53182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G53182

CM. 111789

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2727 Edmondson AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Anderson, Edward Ruark

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife ?Fidella A. Anderson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10 - 1876

8. AGE: Years 71 | Months 3 | Days 23 | If less than one day hr. min.

9. Birthplace MD. Balto.
(Town, county, and state)

10. Usual Occupation Inspector

11. Industry or business Balto. City

FATHER
12. Name John M. Anderson
13. Birthplace ~~Mxxx~~ Lancaster, Pa.

MOTHER
14. Maiden Name Lucretia Ruark
15. Birthplace MD. Balto.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/7/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUL 5 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July -5- 19 47, at 10.20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June -29- 1947, to July -3- 19 47, and that I last saw h im alive on July - 3 - 19 47.

Immediate cause of death	Duration
Coronary Occlusion	2 days
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: None
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. E. Robinson Jr. M.D.
Address Balt. City Hosp. Date signed 7/3/47

X

G53183

BALTIMORE CITY HEALTH DEPARTMENT

GM 111780 CERTIFICATE OF DEATH - 13B

Registered No. G53183

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1124 Mosher ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fountain, Sarah

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: ?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? - ? 1870

8. AGE: Years 77 ? 76 | Months | Days | If less than one day hr. min.

9. Birthplace ? Harford County Md
(Town, county and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 5, 1947 (month) (day) (year)
(c) Cemetery or crematory Mount Olivet
Location Baltimore City

18 (a) Funeral director Joseph A. Sterb
(b) Address 661 W Baltimore St

19 (a) JUL 5 - 1947 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 - 1947, at 9.00A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 28 1947, to July -2 47, and that I last saw her alive on July 2 - 1947

Immediate cause of death	Duration
Pulmonary TB	?
Due to	
Due to	
Other Conditions Arteriosclerotic Heart Dis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. C. Robinson Jr. M.D.

Address Balt. City Hosp. Date signed 7/3/47

G53184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

106B

Registered No. G53184

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1311 W. Pratt St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1311 W. Pratt St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry E. Humm

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Lilly M. Humm
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Dec 12 1876

8. AGE: Years 70 | Months 6 | Days 21 | If less than one day hr. min.

9. Birthplace Maryland (Town, county and state)
10. Usual Occupation Paper Hanger
11. Industry or business Self

FATHER 12. Name Edward ? Humm
13. Birthplace

MOTHER 14. Maiden Name Jane Renney
15. Birthplace Maryland

16 (a) Informant Lilly M. Humm
(b) Address 1311 W. Pratt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 7 1947 (day) (year)
(c) Cemetery or crematory Glenn Haven M.P. Co. Md
Location Balto Md

18 (a) Funeral director Pfaff & B. M. Walter
(b) Address Pratt & Stricker St

19 JUL 5 1947 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 1947, at 8 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 July 1947 to 3 July 1947 and that I last saw him alive on 3 July 1947

Immediate cause of death Congestive heart failure — Duration Approx 6 yrs

Due to Pneumonia

Due to Bronchiectasis, chronic severe

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Millard J. Trafford Jr. M.D.
Address 1326 W Lombard St Date signed July 5 1947

VS 190

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G53185 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun & [illegible]
(c) Hospital or institution Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore Co
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 101 N Carey St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth O'Hara

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: John Leo O'Hara
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Nov 3 1888
8. AGE: Years 58 | Months 8 | Days 1 | If less than one day: hr. — min.
9. Birthplace Baltimore City Md.
(Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business Private family

FATHER
12. Name Julius Koch
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown Augusta (?)
15. Birthplace Germany

16 (a) Informant Husband (John Leo O'Hara)
(b) Address 101 N Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jul 7, 1947 (month) (day) (year)
(c) Cemetery or crematory Balto. Natl. Cem.
Location Balto., Md.

18 (a) Funeral director A. Raymond Evans
(b) Address 1705 S. Charles St.

19 (Signature and title) Huntington Williams, M.D. Registrar
Jul 5 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Jul 4 1947, at 2 33 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3 Jul 1947, to 4 Jul 1947, and that I last saw her alive on 4 Jul 1947.

	Duration
Immediate cause of death: Cerebro-vascular accident	
Due to: Hypertension	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert R Remands M.D.
Address Franklin Square Hosp. Date signed 7-7-1947

VS 150

G53186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1243

Registered No. G53186

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division
(c) Hospital or institution: Provident 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 802 N. Carrollton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edna Ellison

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: N | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/7/08

8. AGE: Years 38 | Months 9 | Days 25 | If less than one day hr. min.

9. Birthplace Washington, D. C. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Frank Arthur
13. Birthplace Washington D C

MOTHER
14. Maiden Name Read
15. Birthplace Washington D C

16 (a) Informant Maurice Ellison
(b) Address 802 N. Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 5th 47 (month) (day) (year)
(c) Cemetery or crematory Harmony
Location Wash. D. C.

18 (a) Funeral director Thos. G. Hayden
(b) Address 1210 N. Carrollton Ave

19 (a) JUL 5 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/2 1947 at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/30 1947, to 19 , and that I last saw h ER alive on 7/2 1947.

Immediate cause of death	Uremia	Duration
Due to	Nephritis	
Due to		
Other Conditions	Cirrhosis of Liver	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. McDonald
Address 644 N. Carey Date signed 7/3/47 D.

VS 150

G53187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G53187 Registered No. 1310

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 753 Dolphin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Chester

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: N | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/13/89

8. AGE: Years 57 | Months 7 5 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas Carey
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Eliz Ann
15. Birthplace Balto Md

16 (a) Informant Thelma Johnson
(b) Address 753 Dolphin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-5-47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Memorial
Location Balto Co. Md

18 (a) Funeral director Charles Sterling
(b) Address 510-12 Cantrell Ave

19 (a) JUL 5 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150 10-52 10M 61.

MEDICAL CERTIFICATION

20. DATE OF DEATH 6/30 19 47 at 11:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/30 19 47 to 6/30 19 47, and that I last saw h[illegible] alive on 6/30 19 47.

Immediate cause of death	Duration
(a) Cerebro Vascular Accident	
Due to Hypertensive C-V Renal Disease.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. McDonald
Address 844 N. Carey Date signed 7/5/47 D.

X

G53188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1314

G53188 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 19 W. 27th street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 19 W. 27th street
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ELEANORE McCROSSON

3 (b) If veteran, name war ---
3 (c) Social Security Account No. ----

4. Sex: Female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife ---
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH - 17 - 1874

8. AGE: Years 73 | Months 3 | Days 16 | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation RETIRED NURSE

11. Industry or business

FATHER
12. Name John McCrosson
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret McGarrell
15. Birthplace Ireland

16 (a) Informant JOHN G. McCROSSON
(b) Address 19 W. 27TH ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/7/47 (month) (day) (year)
(c) Cemetery or crematory St. Peter's
Location

18 (a) Funeral director Chas. J. Evans Son Inc.
(b) Address 118 W. Mt. Royal Ave.

19 (a) JUL 5 1947 Huntington Williams, M.D. Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 1947 at 11:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1945 to July 3 1947, and that I last saw her alive on July 2 1947

	Duration
Immediate cause of death: Heart Failure	1 week
Due to: Cardio-Vascular Renal Disease	12 yrs.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

29. Signature Edward O'Donovan M. D.
Address 730 Gay St. Date signed 7/8/47

G53189

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937.

Registered No. G53189

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Type correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 845 S. Bond Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 845 S. Bond Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS FERENC (FELENC)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anna
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) July 17, 1863

8. AGE: Years	Months	Days	If less than one day
83	11	18	hr. min.

9. Birthplace Ocieka, Poland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Adalbert Ferenc
13. Birthplace Ocieka, Poland

MOTHER
14. Maiden Name Tekla Byk
15. Birthplace Ocieka, Poland

16 (a) Informant Mrs. Mary Malecki
(b) Address 845 S. Bond Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/7/47 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M. J. Sadowski & Sons
(b) Address 1808 Eastern Avenue

19 (Date rec'd by registrar) JUL 5 - 1947 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1947, at 24 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1947, to July 4 1947, and that I last saw h— alive on July 3 1947.

Immediate cause of death	Duration
Myocardial Insufficiency	3 days.
Due to Chronic Myocarditis	4 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John V. Engelbrecht
Address 1802 Eastern Ave Date signed 7-5-47 (M. D.)

G53190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 92D

Registered No. G53190

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2127 Dukeland St.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2127 Dukeland St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice I. Faithful

3 (b) If veteran, name war: --

3 (c) Social Security Account No.: --

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or ~~wife~~: Wm. A. Faithful
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1861

8. AGE: Years 85 | Months 8 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name John Thomas Peregoy
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth J. Sterling
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. John W. Marchant
(b) Address 2127 Dukeland St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-5-47 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Loudon Park
Location Baltimore, Md.

18 (a) Funeral director L. Howard Strong
(b) Address 3207 W. North Ave.,

19 (a) JUL 5 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 5.00

20. DATE OF DEATH July 3, 1947 at A.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1946 to July 3, 1947 and that I last saw her alive on June 27, 1947.

Immediate cause of death	Duration
Myocarditis about	1 yr.
Due to Advanced Arteriosclerosis	
Due to and hypertension	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter E. Treblett M.D.
Address 2220 Garrison Blvd. Date signed 7/3/47

VS 150

G53191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G53191

Registered No.

GM. 111705

46M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE.
(c) Hospital or institution:
Balto. City Hospitals 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2121 Herbert ST. Z 17
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Claude E. Brunner)
Brunner Claude

3 (b) If veteran, name war: Spanish-American
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Catherine E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. -9 - 1877

8. AGE: Years	Months	Days	If less than one day
69	10	24	hr. min.

9, Birthplace MD.
(Town, county, and state)
10. Usual Occupation Tinner
11. Industry or business

FATHER
12. Name Hamilton Brunner
13. Birthplace MD.

MOTHER
14. Maiden Name ?
15. Birthplace VA.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern AVE.

17 (a) Burial (b) Date thereof 7-7-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.

19 (a) JUL 5 - 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July -3-47 1947, at 7.45A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 25 To 47 to July - 3 1947, and that I last saw h Im alive on July -3 -19 47.

Immediate cause of death	Duration
Concussion of	1
Due to S. I Realpan-	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Com
of autopsy: Non

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J C Robinson Jr M. D.
Address Balt. City Hosp. Date signed 7/3/47

C53192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

Registered No. C53192

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 900 N. Port St.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 900 N. Port St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH ZELENY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mary A. (nee Kosak)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1885

8. AGE: Years	Months	Days	If less than one day
61	10	23	hr. min.

9. Birthplace Austria
(Town, county, and state)
10. Usual Occupation Cutter (Tailor)
11. Industry or business

FATHER
12. Name Alois Zeleny
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Frances Dvorak
15. Birthplace Czechoslovakia

16 (a) Informant Mrs. Mary A. Zeleny - wife
(b) Address 900 N. Port Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/5/47 (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Horner's Lane, Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (Date received) JUL 5 1947 (Signature of Huntington Williams, M.D.) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2, 1947 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 14 1947 to July 2 1947 and that I last saw h alive on 19

Immediate cause of death	Duration
Carcinoma of Lung (R)	2 mos
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Joseph Zeleny M.D.
Address 2200 E Madison St Date signed 7/3/47

G53193 — BALTIMORE CITY HEALTH DEPARTMENT — G53193 Registration No.

CERTIFICATE OF DEATH

93a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1036 N. Durham St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1036 N. Durham St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sidney Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Eli Taylor

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Dec. 5 1893

8. AGE: Years 53 | Months 6 | Days 25 | If less than one day ..... hr. ..... min.

9. Birthplace Lancaster Va (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Richard Jones

13. Birthplace Lancaster Va

MOTHER 14. Maiden Name Lavinia Smith

15. Birthplace Lancaster Va

16 (a) Informant Blanche Taylor

(b) Address 1015 Edmondson ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 5. 1947 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem

Location Brooklyn Md

18 (a) Funeral director Chas. B. Wilson

(b) Address 1000 Broadway ave

19 (a) 1947 Registered by registrar Hunter Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1947, at 8 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1947 to June 30 1947, and that I last saw h alive on June 30 1947.

Immediate cause of death	Duration
Acute Myocarditis	1 d
Due to Cerebral Hemorrhage	10 d.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. A. Berry M. D.

Address 1420 E. Chase Date signed 7-3-47

G53194 BC# D83349 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 159 G53194 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution: Franklin Square
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ days
(e) Length of stay in Baltimore (yrs., mos., or days) 1½ days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Linthicum (If outside city or town limits, write RURAL and give town)
(d) Street No. Madera Road (If rural, give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME WATERS, BABY GIRL

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 4 July 47

8. AGE: Years | Months | Days 1½ | If less than one day — hr. — min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER
12. Name Albert H. Waters
13. Birthplace Laurel, Md.

MOTHER
14. Maiden Name Virginia V. Wood
15. Birthplace Easton, Md.

16 (a) Informant Albert H. Waters
(b) Address Madera Rd, Linthicum Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-6-47 (month) (day) (year)
(c) Cemetery or crematory Davy Hill
Location Laurel, Md.

18 (a) Funeral director Arthur J. Walters
(b) Address Laurel, Md.

19 (a) 7-6-1947 (Date rec'd by registrar) (b) Harrington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 July 1947 at 2:30 P M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4 July 1947 to 5 July 1947 and that I last saw her alive on 5 July 1947.

Immediate cause of death Atelectasis — Duration

Due to Prematurity

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature [illegible] M. D.
Address Franklin Square Date signed 7-6-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53195

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 937

G53195

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Sinai Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State..... (b) County.....
(c) City or town Bristol Va
(If outside city or town limits, write RURAL and give town)
(d) Street No.....
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Claude Hobbs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	W	single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8 94

8. AGE: Years	Months	Days	If less than one day
53			..... hr. ..... min.

9. Birthplace.....
(Town, county, and state)
10. Usual Occupation.....
11. Industry or business

FATHER
12. Name.....
13. Birthplace Va.

MOTHER
14. Maiden Name.....
15. Birthplace

16 (a) Informant.....
(b) Address

17 (a) removal (b) Date thereof 7 5 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location Bristol Va.

18 (a) Funeral director Philip Herndon Sons
(b) Address 2824 Orleans St

19 (a) 7-6 1947 (b)..... Registrar
(Date rec'd by registrar)
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH .....19....., at.....M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-30 19 47 to 7-5 19 47, and that I last saw h. alive on 7-5 19 47.

Immediate cause of death Cardiac failure
Coronary

Due to coronary thrombosis
myocardial infarction

Due to arteriosclerotic heart Dis.

Other Conditions
left sided hemiplegia
(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy: coronary thrombosis

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature E. T. Wedgman MD
M. D.
Address Sinai Hosp Date signed 7-5-47

X

G53196

518270

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G53196
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 733 N. Eden St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willie Butler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black.	Single.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-6-10

8. AGE: Years	Months	Days	If less than one day
36	8	28	hr. min.

9. Birthplace S. C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Willie Butler
13. Birthplace S. C.

MOTHER
14. Maiden Name Lulu Brown
15. Birthplace S. C.

16 (a) Informant Reconda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 7/6/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Edgefield S. C.
Location

18 (a) Funeral director Elbert Wilson
(b) Address 1000 Druid Park Ave

19 (a) 1947 (Date Rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 1947 at 3. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947 to July 3 1947, and that I last saw him alive on July 3 1947.

Immediate cause of death: Circulatory Failure — Duration

Due to: Lobar Pneumonia - Type I pneumococcus

Due to

Other Conditions: Chronic alcoholism

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. H. Gibson M. D.
Address Johns Hopkins Hosp. Date signed 4 July '47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53197 — BALTIMORE CITY HEALTH DEPARTMENT — G53197 Registered No.

CERTIFICATE OF DEATH X 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CREENE & LOMBARD
(c) Hospital or institution: UNIVERSITY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 DAY
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County ANNE ARUNDEL
(c) City or town Harness Creek A.A. Co
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CHRIS B. NELSON

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife SALLIE H. Nelson
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Jan 5 - 1899

8. AGE: Years 48 | Months 6 | Days 0 | If less than one day ... hr. ... min.

9. Birthplace NEW JERSEY (Town, county, and state) Dec.
10. Usual Occupation ARCHITECT - Annapolis Ship
11. Industry or business Ship Building Yd.

FATHER
12. Name ERASMUS NELSON
13. Birthplace DENMARK

MOTHER
14. Maiden Name MAREN BERTELSON
15. Birthplace DENMARK

16 (a) Informant Sallie H. Nelson
(b) Address Harness Creek A.A. Co Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/8/47 (month) (day) (year)
(c) Cemetery or crematory St. Anns Ann
Location Annapolis Md

18 (a) Funeral director E. Millis Lamneau
(b) Address 1003 W Baltimore St.

19 (a) ... (Date rec'd by registrar) (b) ... Registrar
Huntington Williams, M.D.

VS 1947 6 - 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 5 1947, at 1.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-5 1947, to 7-5 1947, and that I last saw him alive on 7-3 1947.

Immediate cause of death ACUTE MYOCARDIAL INFARCTION — Duration
Due to CORONARY OCCLUSION
Due to
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sidney H. Sacks, M.D.
Address Univ. Hosp. Date signed 7-5-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G53198 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1824 N. Washington St
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1824 N. Washington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred F. Hinke

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
—	212-01-1719	Male	White	widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3, 1876

8. AGE: Years	Months	Days	If less than one day
71	2	1	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Anton Hinke
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Charles Hopewood
(b) Address 3027 Kenyon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/7/47 (month) (day) (year)
(c) Cemetery or crematory Oakland Cemetery
Location Eastern ave

18 (a) Funeral director Howard H. Blight Jr
(b) Address 49 Belair Road

19 (a) 6 JUL 1947 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1947 10:00 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from June 26 1947 to July 4 1947 and that I last saw him alive on July 4 1947.

Immediate cause of death: Cerebral Apoplexy — 8 days.
Due to: Cerebral Hemorrhage ? Arteriosclerosis + Hypertension
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Kemp
Address 700 E. Pratt St. Date signed 7/7/47 M.D.

G53199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G53199 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Greenspring Ave
(c) Hospital or institution: Levindale
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 74 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Jablon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Philip

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 75 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER: 12. Name Lazor

13. Birthplace Russia

MOTHER: 14. Maiden Name Namora

15. Birthplace Russia

16 (a) Informant Leon Jablon

(b) Address 2300 Whittier Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-6-47 (month) (day) (year)

(c) Cemetery or crematory Sinai

Location

18 (a) Funeral director Jack Levin Inc

(b) Address 1439 E. Balto St

19 (a) Registrar Williams M.D. (Date received by registrar) Registrar

JUL 6 - 1947

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1947 at 6.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1944 to 7-6 1947 and that I last saw h-r alive on 7-6 1947.

Immediate cause of death: Bronchopneumonia

Due to: Cerebral arteriosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H Edmund Levin

Address Levindale Date signed 7/6/47

G53200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

G53200 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1850 W. Baltimore St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland

(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1850 W. Baltimore St.
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) **FULL NAME** Arthur K Welsh

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-12-0203

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Jennie

6 (c) If alive, give age 9. years

7. Birth date of deceased (mo., day, yr.) JAN 11 1883

8. AGE: Years 64 | Months 5 | Days 23. | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation General Work

11. Industry or business Fruit Loom Clothing Co.

FATHER 12. Name Randolph D Welsh

13. Birthplace Maryland

MOTHER 14. Maiden Name Ida Mearinon

15. Birthplace Maryland

16 (a) Informant Mrs Ida M. Welsh

(b) Address 1850 W. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 17 47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore Md

18 (a) Funeral director H. D. Hilbert & Son

(b) Address 1300 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

6 vs 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1947 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1st 1947 to July 17 1947, and that I last saw h alive on July 17 1947.

Immediate cause of death Carcinoma of bladder — Duration ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Harry Glassman M. D.

Address 2672 Madison Ave Date signed July 23

G53201 BALTIMORE CITY HEALTH DEPARTMENT G53201
CERTIFICATE OF DEATH 1/21a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 927 W. Fayette St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 927 W Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Cleves Thompson.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Edward Thompson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 16, 1895

8. AGE: Years: 51 | Months: 6 | Days: 18 | If less than one day: hr. min.

9. Birthplace: Wilmington, Delaware (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER — 12. Name: Joshua Johnson.
13. Birthplace: Md.

MOTHER — 14. Maiden Name: Elizabeth ,
15. Birthplace: Md.

16 (a) Informant: Mrs. Mildred Griffin
(b) Address: 3023 N. Schroeder St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-6-1947 (month) (day) (year)
(c) Cemetery or crematory: Mt. Calvary
Location:

18 (a) Funeral director: Mrs Katie R. Williams
(b) Address: 322 N. Schroeder St.

19 (a) JUL 6 1947 (Date received by registrar) (b) Registrar

VS 150 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 19 47 at 2:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 47, to July 3 19 47, and that I last saw h alive on June 19 47.

Immediate cause of death: Cerebral Embolism
Due to:
Due to:
Other Conditions: None

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration: 4 hours

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Paul L. Lapus M. D.
Address: 527 N. Grand Ave. Date signed July 7 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G53202
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1638 Hanover St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1638 Hanover St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna M. Winkler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Henry P. Winkler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6 - 1877

8. AGE: Years 69 | Months 8 | Days 28 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER
12. Name Antony ullman
13. Birthplace Germany

MOTHER
14. Maiden Name Pauline Kragel
15. Birthplace Germany

16 (a) Informant Mrs Lillian C. Simon
(b) Address 1638 Hanover St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 7-1937 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A. A. Co. Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1176 Light St.

7 - 1937 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/3 1937 at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/10 1937 to 6/30 1937 and that I last saw her alive on 6/30 19

Immediate cause of death: Myocardial degeneration

Due to: Arteriosclerosis

Due to:

Other Conditions: Myocardial degeneration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 3 Mo - as for abd pain

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. J. Gleason M. D.

Address 107 E. West St Date signed 7/3/37

X

G53203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Reg. No. G53203

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4909 Grindon Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 46 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4909 Grindon Avenue
(Rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Clara A. Leitschuh

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4 Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Florian Leitschuh
6 (c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): May 11, 1879

8. AGE: Years: 68 | Months: 1 | Days: 23 | If less than one day: ########## hr. ########## min.

9. Birthplace: Germany (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Schendler
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15 Birthplace: Germany

16 (a) Informant: Florian Leitschuh
(b) Address: 4909 Grindon Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/7/47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Frederick Road, Balto: Md.

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) 1947 (Date rec'd by registrar) (b) ########## Registrar

V S 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3rd. 1947, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1947 to July 3 1947. and that I last saw her alive on July 2 1947.

Immediate cause of death: Myocardial Insufficiency — Duration: 1 mo

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: [illegible] M. D.
Address 9858 Harford Rd Date signed 7/4/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53204

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G53204

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4800 Crowson Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4800 Crowson Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lena R. Williamson

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, ~~married, widowed,~~ or divorced
N	NONE	Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) July 6 1865
8. AGE: Years 81 | Months 11 | Days 28 | If less than one day hr. min.
9. Birthplace Ohio (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Piatt Williamson
13. Birthplace N.Y.

MOTHER
14. Maiden Name Bessie W. Allan
15. Birthplace Ohio

16 (a) Informant Mrs. Bartlett
(b) Address 4800 Crowson Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/8/47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md
18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.
19 (a) [illegible] 7 1947 Huntington Williams M.D. Registrar's Address 3902 Greenmount Ave

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1947, at 4:45 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 4 1947 to 4 July 1947 and that I last saw h[illegible] alive on 3 July 1947.

Immediate cause of death	Duration
Myocardial failure	
Due to Broncho pneumonia	1 week
Due to	
Other Conditions Parkinsons disease (Include pregnancy within 3 months of death)	5 yrs

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN Underline the cause to which death should be charged statistically)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Lloyd E. Saylor M. D.
Date signed 5 July 1947

VS 150

G53205

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G53205

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 N. Broadway
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carolina Speer

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1860

8. AGE: Years 86 | Months 10 | Days 24 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Ferdinand Speer
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Fink
15. Birthplace Germany

16 (a) Informant Dorothy Speer
(b) Address 1700 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 8, 1947 (month) (day) (year)
(c) Cemetery or crematory Cemetary
Location Loudon Park

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (c) Filed by registrar JUL 7 - 1947 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1947, at 11:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/29/1947 to 7/4/1947 and that I last saw h[illegible] alive on 7/3 1947.

Immediate cause of death: Myocardial insufficiency — Duration: 3 days

Due to: Chronic myocarditis. — 3 mos

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature H. H. Lawton
Address 1517 E. Lafayette Ave. Date signed 7/3/47

G53206

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G53206

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 703 N. Rose St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Marcellus Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-28-1865

8. AGE: Years 81 | Months 11 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas Morris
13. Birthplace Md.

MOTHER
14. Maiden Name Winnie Prouty
15. Birthplace Md
Records

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-8-47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Wilhelm & Boyle
(b) Address 1211 E. Fort Ave

19 (a) Filed 7-7-1947 Registrar for Williamsville
(b) Delivered by registrant

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1947, at 10.40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 4 1947, to July 4 1947, and that I last saw her alive on July 4 1947.

Immediate cause of death: Gastric INTESTINAL HEMORRHAGE — Duration: 3 DAYS

Due to: CARCINOMA OF SIGMOID

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Truman D. Stephens M. D.
Address Johns Hopkins Hospital Date signed 7-5-47

G53207

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

G53207

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital 25 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4402 W. Bay St. Curtis Bay
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RICHARD E. CHANEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1. 1911

8. AGE:	Years	Months	Days	If less than one day
	35	11	3	hr. min.

9. Birthplace Anne Arundel County
(Town, county, and state)

10. Usual Occupation Musician

11. Industry or business self

FATHER
12. Name Walter Chaney
13. Birthplace Maryland

MOTHER
14. Maiden Name Naomi V. Turner
15. Birthplace Maryland

16 (a) Informant Naomi V. Burkhart
(b) Address 2412 Sisson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/7/47 (month) (day) (year)

(c) Cemetery or crematory Bethel
Location Anne Arundel Co Md

18 (a) Funeral director Milburn Bros Inc
(b) Address 1217 E Pont St

19 (a) JUL 7 - 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4, 1947, at 12.05 M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 7-4-47 ? M.
(b) Where did injury occur? Fd drowned-Curtis Bay Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Found drowned

23. Signature Earl L. Hoyer M.D.
Medical Examiner.
Date signed 7-5-47

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G53208

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G53208

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2502 Erdman Avenue
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2502 Erdman Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Stanley C. Preston

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife 7
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12 1890

8. AGE: Years	Months	Days	If less than one day
About 56	9	22	hr. min.

9. Birthplace Harford County, Md. (Town, county, and state)
10. Usual Occupation Supervisor Baltimore City
11. Industry or business Schools

FATHER
12. Name James R. Preston
13. Birthplace Maryland

MOTHER
14. Maiden Name Pricilla L. Wildt
15. Birthplace Maryland

16 (a) Informant Grayson Preston
(b) Address 4418 Grand View Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 7 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Parkwood

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 2517 St. Paul Street

19 (a) JUL 7 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 July 1947, at 12:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3 March 1947 to 4 July 1947, and that I last saw h... alive on ... 19...

Immediate cause of death	Duration
Uremia	1 week
Due to Carcinomatosis - renal Disease	?
Due to	
Other Conditions Old. Art. Coronary Infection	16 mos.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Samuel Silverfarb M.D.
Address 714 E. Preston Date signed July 7

X

G53209

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 109a

M G53209 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3806 Barrington Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3806 Barrington Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willard M. Hurlock ✓

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-16-5076

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 28 1899

8. AGE: Years	Months	Days	If less than one day
47	9	6	hr. min.

9. Birthplace Balto. Md.
(Town, county and state)

10. Usual Occupation Watchman

11. Industry or business B & O R. R.

FATHER
12. Name Elmer E. Hurlock
13. Birthplace Hurlock Md.

MOTHER
14. Maiden Name Isabelle Allen
15. Birthplace Balto. Md.

16 (a) Informant Ellworth A. Hurlock
(b) Address 3603 Rosedale St.

17 (a) Burial (b) Date thereof 7/7/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William Cox Inc.
(b) Address 1217 St. Paul St.

1947 JUL 7 Registered by Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3rd 1947, at M

21. I certify that death occurred on the date above stated, that I attended deceased from July 1 1947 to July 3 1947 and that I last saw h- alive on July 3 1947.

Immediate cause of death: Kidney Disease

Duration: 3 Days

Due to

Due to

Other Conditions: High Blood Pressure

Duration: 1 yr.

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Arthur C Hagen M. D.
Address 770 Fairmount Ave Date signed 7/14/47

VS 150

X

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G53210

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G53210 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 W. Cold Spring Lane
(c) Hospital or institution:
Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 W. Cold Spring Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Woodward W. Marcus

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 20, 1875

8. AGE: Years	Months	Days	If less than one day
71	8	14	hr. min.

9. Birthplace Woodbury, N. J.
(Town, county, and state)
10. Usual Occupation Retired Clergyman
11. Industry or business

FATHER
12. Name Andrew Marcus
13. Birthplace New Jersey

MOTHER
14. Maiden Name Susan Shoot
15. Birthplace New Jersey

16 (a) Informant Carlton P. Marcus
(b) Address 1101 Taylor Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 7 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Cedar Hill

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (Date received) July 7, 1947 Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1947 at 2 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 15 1946 to 1947
and that I last saw h/m alive on July 3 1947

Immediate cause of death Carcinoma - Colon - Duration 1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Norman L Kinnan M. D.
Address 3803 Edmondson Ave Date signed 7-8-47

G53211 Bk # G82453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 161 G-58004 G-53211

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Brooklyn (If outside city or town limits, write RURAL and give town)
(d) Street No. Box #327 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wallace

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27, 1947

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: David Wallace
13. Birthplace: unknown

MOTHER
14. Maiden Name: Gladys Dotson
15. Birthplace: Maryland

16 (a) Informant: Hospital Records
(b) Address: Johns Hopkins Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Loc: Johns Hopkins Medical School JUL 1 1947

18 (a) Funeral direct: Commissioner of Health
(b) Address

JUL 7 - 1947 (Date rec'd by Registrar) (b) Washington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1947, at 3:20P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 27 1947 to June 28 1947, and that I last saw h im alive on June 28 1947.

Immediate cause of death: Cerebral anoxia
Fetal distress in utero.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Russell Jordan M. D.
Address 508 N. Broadway Date signed 6-28-47

G53212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G53212
Registered No.

516580 160a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County A. A. County
(c) City or town Rothrian
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Blake

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-4-47.

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Blake
13. Birthplace 2,

MOTHER
14. Maiden Name Lucille 2,
15. Birthplace 2,

16 (a) Informant Reinds
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Loc Johns Hopkins Medical Schoo JUL 1 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUL 7 - 1947 (b) (Date rec'd by Registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 1947, at 12 - M midnight

21. I certify that death occurred on the date above stated; that I attended deceased from June 4 1947, to June 5 1947, and that I last saw her alive on June 5 1947.

Immediate cause of death prematurity — Duration

Due to

Due to

Other Conditions atelectasis
intra cranial hemorrhage
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Johns Hopkins Hosp. Date signed 6-6-47

159

G53213 BC#782358

BALTIMORE CITY HEALTH DEPARTMENT VG53213 #23319
CERTIFICATE OF DEATH 159 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 17
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 717 Pierce Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME McNeil

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28, 1947

8. AGE: Years	Months	Days	If less than one day
			hr. 55 min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Lee McNeil
13. Birthplace North Carolina

MOTHER
14. Maiden Name Christine Craven
15. Birthplace North Carolina

16 (a) Informant Hospital Records
(b) Address Johns Hopkins Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Loc Johns Hopkins Medical Schools JUL 1 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUL 7 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1947, at 12:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 28 1947, to June 28 1947, and that I last saw him alive on June 28 1947.

Immediate cause of death — Duration
Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Russell Jordan M. D.
Address 508 N. Broadway Date signed 6-27-47

G53214 Blk B-82445 141208 101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G53214 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1223-E. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby (Alberta) Wallace

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: black | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-27-47

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace: Md J.H.H. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name: Theodore Wallace
13. Birthplace: P

MOTHER 14. Maiden Name: Alberta Gamble
15. Birthplace: N.C.

16 (a) Informant: records
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location: Johns Hopkins Medical School JUL 1 1947

18 (a) Funeral director: Commissioner of Health
(b) Address

19. JUL 7 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1947, at 2 15/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-27- 1947 to 6-29- 1947, and that I last saw her alive on 6-29 - 1947.

Immediate cause of death: Hemorrhage of newborn — Duration

Due to: Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Russell Jordan
Address: 809 N. Broadway Date signed 6-29-47

G53215

517902.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

G53215
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Harford
(a) State Md (b) County [redacted]
(c) City or town Street.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Johnson.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-25-47.

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace: md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Benj. F Johnson.
13. Birthplace 2.

MOTHER
14. Maiden Name 2. 2.
15. Birthplace 2.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo JUL 1 1947

18 (a) Funeral director
(b) Address Commissioner of Health

JUL 7 - 1947 (Date rec'd by local registrar) (b) Thurlington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 1947 at 6.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 25 1947, to June 26 1947 and that I last saw her alive on June 26 1947.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to: Prematurity (1260 gms)

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D H Huggins M. D.
Address Johns Hopkins Hospital Date signed 6-4-47

G53216

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. G53216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST.
(c) Hospital or institution: ST. JOSEPH'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2049 E. NORTH AVENUE
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. ANNA M. SMITH (ANNA MARGARET (CORKRAN) SMITH

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: WALTER E. SMITH
6 (c) If alive, give age: 39 years
7. Birth date of deceased (mo., day, yr.): 1/1/95
8. AGE: Years 52 | Months 6 | Days 5 | If less than one day ____ hr. ____ min.
9. Birthplace: BALTIMORE - MARYLAND (Town, county, and state)
10. Usual Occupation: HOUSEWIFE
11. Industry or business: —

FATHER
12. Name: James Connor
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Katherine Slagle
15. Birthplace: Maryland

16 (a) Informant: Mr. Walter E. Smith
(b) Address: 2049 E. North Avenue

17 (a) burial (Burial, cremation, or removal) (b) Date thereof: 7-7-47 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) 7-7-1947 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/4/ 1947, at 12.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/12 1947, to 7/4 1947, and that I last saw HER alive on ____ 19____.

Immediate cause of death	Duration
MASSIVE HEMORRHAGE	
Due to GASTRIC CARCINOMA	6 MONTHS
Due to	
Other Conditions SECONDARY ANEMIA CHRONIC MYOCARDITIS	"

(Include pregnancy within 3 months of death)

Date of operation NONE
Major findings of operation: CHRONIC MYOCARDITIS
of autopsy: Scarring, Duodenal Ulc, Gastric Dilatation

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Henry J. Hourihan M. D.
Address: ST. JOSEPH'S HOSPITAL Date signed: 7/4/47

G53217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G53217

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 31st & Wyman Park Drive
(c) Hospital or institution: U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mo
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County None
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2309 Tiago Pkw. Tioga (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Appleffeld Milton Carl

3 (b) If veteran, name war: World War II
3 (c) Social Security Account No.:
4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Lillian Appleffeld
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 6-17-15
8. AGE: Years 32 | Months — | Days 20 | If less than one day — hr. — min.
9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Salesman Real Estate
11. Industry or business

FATHER
12. Name Samuel Appleffield
13. Birthplace Poland

MOTHER
14. Maiden Name Ethel Sherman
15. Birthplace Poland

16 (a) Informant Lillian Applefeld
(b) Address Alhambra Apts
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-7-47 (month) (day) (year)
(c) Cemetery or crematory B'Nai Israel
Location Southern Ave
18 (a) Funeral director Jack Lewis Inc
(b) Address 409 E Balto St
19 (a) Filed 7-1947 (Date received by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-6 1947, at 6:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-24 1947, to 7-6 1947, and that I last saw h/M alive on 7-6 1947.

Immediate cause of death: Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: SAME

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury W.S. SNELL

23. Signature M. D.
Address VA Mount Royal Date signed 7-6-47
Baltimore Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53218

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G53218
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5740 Jonquil Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 55yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5740 Jonquil Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles D. Land

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Jennie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name unknown
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Mrs. Land
(b) Address 5740 Jonquil Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-8-47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location

18 (a) Funeral director Jack Reuss Inc
(b) Address 1431 E. Baltimore St

19 (Date rec'd by registrar) JUL 7 1947 Washington Metropolitan

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-4-1947 at 10 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/1 1945 to 7/4 1947 and that I last saw h/ alive on 7/4 1947.

Immediate cause of death Coronary Thrombosis — Duration Sudden
Due to Atherosclerotic Cardio-Vascular Disease — 7
Due to
Other Conditions Hemiparesis — 2yr

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph S. Blum, M.D.
Address 1206 E. Preston St Date signed 7/3/47

G53219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G53219 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1[illegible]
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 23

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County None
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1221 Slott St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sophie Boecher

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Henry Boecher
6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) [illegible]

8. AGE: Years 73 (74) Months 09 (10) Days 08 If [illegible] hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business None - Same

FATHER
12. Name Mr C Baekert
13. Birthplace Germany

MOTHER
14. Maiden Name Ackerman Barbara Ulmer
15. Birthplace Pennsylvania

16 (a) Informant Son-Mr Charles C Boecher
(b) Address 961 Ramsey ST City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/8/47 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave.

18 (a) Funeral director George Arambich
(b) Address 525 N. Hyndhurst ST.

19 (a) [illegible] 7 - 1947 (b) [illegible] (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 July 1947 at 4 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3 July 1947 to 5 July 1947 and that I last saw her alive on 4 July 1947.

Immediate cause of death — Cardiac failure

Due to Diabetes (with Diabetic Gangrene

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation No
Major findings of operations: None

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible] M.D.
Address [illegible] Date signed 7/5/47

G53220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G53220

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts
(c) Hospital or institution: Univ. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 dy

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Sykesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rt 64
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY A. KEEFER

3 (b) If veteran, name war | 3 (c) Social Security Account No:

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25, 1949

8. AGE: Years | Months: 1 | Days: 12 | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Morris Keefer
13. Birthplace Md.

MOTHER
14. Maiden Name Grace Gibson
15. Birthplace Pa.

16 (a) Informant Grace Gibson Keefer
(b) Address Sykesville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-8-47 (month) (day) (year)
(c) Cemetery or crematory Baile Cemetery
Location Dennings, Md.

18 (a) Funeral director C. Harry Ulsen
(b) Address Sykesville, Md.

19 (a) 7-[illegible]-1947 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1947 at 3:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 3 1947 to July 7 1947. and that I last saw [illegible] alive on July 7 1947.

Immediate cause of death: Asphyxiation asphyxiation — Duration
Due to: aspiration of vomit
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 7/5/47
Major findings of operation: Appendectomy perforated appendix
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Olsen
Address [illegible] Date signed 7/8/47

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53221 BCH 082504

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

161c

Registered No. G53221

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ~~same~~
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 820 S. Port St - 2d
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Gregory Anthony Olea

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2, 1947

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation.....
11. Industry or business

FATHER
12. Name Edward J. Olea
13. Birthplace Baltimore

MOTHER
14. Mriden Name Claudelle Weber
15. Birthplace Baltimore

16 (a) Informant Edward J. Olea
(b) Address 820 S. Port st

17 (a) Burial (b) Date thereof 7-7-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore Co. Md.

18 (a) Funeral director George A Weber
(b) Address 705 S Ann st

19 (a) JUL 7 - 1947 Huntington Williams
(Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1947, at 5:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1947 to July 5 1947 and that I last saw h.m alive on July 5 1947.

Immediate cause of death Coronary thrombosis fatal

Due to.....

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

Duration
1

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature William B. Schmitz M. D.
Address Mercy Hospital Date signed 7-5-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REGISTRY RESERVED FOR BINDING

G53222 — BALTIMORE CITY HEALTH DEPARTMENT — Reg. G53222

No. 111304

CERTIFICATE OF DEATH 45F

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
Street No. 1523 William Street
(If rural give location)
(c) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Francis Conway

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
No	None	Male	White	Widower

6 (b) Name of husband or wife Marian E. Conway
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 29th 1871

8. AGE:	Years	Months	Days	If less than one day
	75	10	6 7	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Supervisor of elections
11. Industry or business Retired

FATHER
12. Name John Conway
13. Birthplace Maryland

MOTHER
14. Maiden Name ? Don't know
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jul 8, '47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. A. Co.

18 (a) Funeral director A. Howard Eland
(b) Address 1400 S. Charles St.

19 (a) JUL 7 - 1947 (Date rec'd by registrar) Huntington for Williams, M.D. Address

MEDICAL CERTIFICATION P M

20. DATE OF DEATH July 5th 1947 19 , at 5.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10/ 19 47, to July 5/ 1947, and that I last saw him alive on July 5th 19 47.

Immediate cause of death Carcinoma of left tonsil with metastasis to left cervical lymph nodes. — Duration 2 wks

Due to

Due to 1. Arteriosclerotic cardio-vascular disease.

Other Conditions 2. Emaciation.

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. D. Gibbs M.D.
Address Baltimore City Hospitals Date signed 7/6/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 15

Registered No. G53223

(over)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 405 McAllister St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 405 McAllister St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Florence M Knight

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Charles S.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12, 1896

8. AGE: Years 51 | Months 3 | Days 23 | If less than one day hr. min.

9. Birthplace Sparrows Pt. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Peter T. Kearney

13. Birthplace Raleigh, N.C.

MOTHER 14. Maiden Name Sarah E. Patterson

15. Birthplace Selden, N.C.

16 (a) Informant Stanley Knight

(b) Address 405 McAllister St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 7, 1947 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Pk.

Location Baltimore Co. Md.

18 (a) Funeral director Wm. Chas. H. Holland

(b) Address 1691 Druid Hill Ave

19 (a) Date received by Local Registrar JUL 7 1947 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4, 1947, at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-15 1947, to 7-4 1947, and that I last saw h[illegible] alive on 7-3 1947.

Immediate cause of death	Duration
Tuberculous Peritonitis	2 mo
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Flynn M. D.

Address 11 E Chase St Date signed 7-6-47

G53224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G53224
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + Saratoga
(c) Hospital or institution: Mercy Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1312 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward T. Costello

3 (b) If veteran, name war: Spanish American
3 (c) Social Security Account No. —

4 Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife ✓
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2nd 1878

8. AGE: Years	Months	Days	If less than one day
69	4	1	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Moulder
11. Industry or business Retired

FATHER
12. Name Andrew Costello
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen McGarrity
15. Birthplace Ireland

16 (a) Informant Mrs Elizbeth M. Arthurs
(b) Address 3404 Auchentoroly Terrace

17 (a) Burial (b) Date thereof 7/8/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd

18 (a) Funeral director John J. Cowan + Son
(b) Address 901-03 Hollins St

19 (a) JUL 7 - 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 1947, at 10:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subarachnoid Hemorrhage - Spontaneous

Due to

Other Conditions Arteriosclerotic C.V. Renal Disease
(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl V. Ryan M.D.
Medical Examiner
Date signed 7-4-47

G53225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G53225

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 520 Dolphin St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 520 Dolphin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SILAS ANTHONY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9, 1876

8. AGE: Years	Months	Days	If less than one day
71	1	24	hr. min.

9. Birthplace Lynchburg, Virginia (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name Monroe Anthony
13. Birthplace Va.

MOTHER
14. Maiden Name Not Known
15. Birthplace " "

16 (a) Informant Mrs. Ollie Anthony
(b) Address 520 Dolphin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-8-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) JUL 7 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH July 4, 19 47 at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/8 19 47 to July 4 19 47
and that I last saw him alive on 7/3 19 47

Immediate cause of death: Cardio-Renal Failure — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 17 E Lafayette Date signed 7-7-47

X

G53226

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937 ✓

Registered No. G53226

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 33rd and Windemere Road
(b) Street address ~~1208~~
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 Windemere Road, City 18 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3.(a) FULL NAME Joseph Arthur Woodburn

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-03-1904

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Hazel H. Woodburn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1887

8. AGE: Years 60 | Months 3 | Days 17 | If less than one day hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name William C Woodburn
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Sarah Glauser
15. Birthplace Pennsylvania

16 (a) Informant Mrs. Hazel H. Woodburn
(b) Address 1208 Windemere Road, City 18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/7/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUL 7 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1947, at 9.20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 23 1947, to July 4 1947, and that I last saw h[illegible] alive on July 4 1947.

Immediate cause of death: Coronary occlusion — Duration: 12 da.
Due to: Arterio-sclerotic heart disease
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N. R. Freeman Jr., M.D.
Address Union Memorial Hosp. Date signed 4 July '47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12 1a

G53227 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1729 Ellamont St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1729 Ellamont St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ADA ROSE FLEISCHER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Louis Fleischer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 21, 1887

8. AGE: Years	Months	Days	If less than one day
69	10	14	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name George M. Atwell
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Margaret Desprant
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Louis Fleischer husband
(b) Address 1729 Ellamont St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/8/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUL 7 - 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1947 to July 5 1947, and that I last saw her alive on June 1 1947.

Immediate cause of death. — Duration
Mitral Regurgitation Recurrent — 1 m d
Bronchitis Chronic — 2 h
Due to Arterio Sclerosis — 10 y
& Hypertension — 10 y
Due to Chr Pulmonary tuberculosis Reparative — 3 m d.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature F A Stevens M. D.
Address 2818 Harford Rd Date signed 7-7-47

C53228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. C53228

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2834 Clifton Ave.
(c) Hospital or institution: 1547
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2834 Clifton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME SARAH ELLEN KETTLE

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband ~~or wife~~ Alfred J. Kettle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23, 1863

8. AGE: Years	Months	Days	If less than one day
83	7	11	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Home
11. Industry or business

FATHER
12. Name Andrew J. Hobbs.
13. Birthplace Md.

MOTHER
14. Maiden Name Mathilda Hunt
15. Birthplace Md.

16 (a) Informant Mr. Carroll W. Kettle
(b) Address 2834 Clifton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/7/47 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

19 JUL 7 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jul. 4, 1947 19 , at 10:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1947 to July 4 1947 and that I last saw her alive on July 4 19 47.

Immediate cause of death	Duration
Cardio-vascular Hypertensive Disease	6 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. L. Gould M. D.
Address 2108 E. Pau[illegible] St. Date signed 7/6/47

X

M. D. B. 1265-2

M. D. B. 1365-9

G53229

HEALTH DEPARTMENT—CITY OF BALTIMORE

G53229

CERTIFICATE OF DEATH

82

1. PLACE OF DEATH

Registered No.

CITY OF BALTIMORE: (No. 938 Armstead way St. W. 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Emma May Beckey

(a) Residence: No. 938 armstead way St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Wilbur

6. DATE OF BIRTH (month, day, year) Aug. 18 1888

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
58	10	19	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Reading Pa

FATHER

13. NAME Ephriom Rosemiller

14. BIRTHPLACE (city or town) (State or country) Reading Pa

MOTHER

15. MAIDEN NAME Emma Haines

16. BIRTHPLACE (city or town) (State or country) Reading Pa

17. INFORMANT Wilbur Beckey

(Address) 938 Armstead Ave

18. [redacted], OR REMOVAL

Place RICETOWN BARKS Co Pa Date JUL 8 1947

19. UNDERTAKER Wilbur C. Beckey

(Address)

20. FILED JUL 7 - 1947 19 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) July 7 1947

22. I HEREBY CERTIFY, That I attended deceased from July 1 1943 to July 7 1947

I last saw h alive on July 7 1947 Death is said to have occurred on the date stated above, at 2 A m.

The **principal cause of death** and related causes of importance were as follows:

	Date of onset
Coronary thrombosis	Sudden
Amyotrophic Lateral Sclerosis	1942

Other **contributory causes** of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in **industry**, in **home**, or in **public place**

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

no If so, specify

(Signed) Geo. M. Baumgardner M. D.

(Address) Balto 6 Md

CAUSE OF DEATH is very important. See instructions on back of certificate.

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53230 110628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G53230 Registered No. 93c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Month
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 287 N. Exter ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Parker Amanda

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married Sep.

6 (b) Name of husband or wife John
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 26 - 1911

8. AGE: Years	Months	Days	If less than one day
36	5	8	hr. min.

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Mack (D)
13. Birthplace MD.

MOTHER
14. Maiden Name Sarah Blackwell (D)
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof July 5 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Balto Co, Md

18 (a) Funeral director Robert E. Williams
(b) Address 15 E. McElderry St

19 (a) (b)
(Date received by registrar) (Registrar)

JUL 7 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 - 1947, at 8.00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 13 - 1947 to July 3 - 1947, and that I last saw her alive on July 3 - 1947.

Immediate cause of death Hypertensive & Rheumatic C-V Disease. — Duration

Due to

Due to

Other Conditions Renal Failure.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert A. Farber M. D.
Address Balto City Hosp. Date signed 7-3-47

G53231

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

G53231

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 0
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 509 S Bentalou St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. John George Hafner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of ~~husband~~ or wife Mrs. Deborah Jane Cannell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 26, 1863

8. AGE: Years	Months	Days	If less than one day
83	8	8	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired Carpenter
11. Industry or business

FATHER
12. Name John F Hafner
13. Birthplace Germany

MOTHER
14. Maiden Name -
15. Birthplace Germany

16 (a) Informant Albert L Hafner
(b) Address 1242 Stevens Ave Hab Thafe

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 7 1947 (month) (day) (year)
(c) Cemetery or crematory Westerly
Location Edmondson Ave + Longwood Sts

18 (a) Funeral director Harry A Wetzler
(b) Address 4401 Edmondson Ave

19 Filed July 7 1947 Registrar Wellington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 July 1947, at 6 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 July 1947 to 3 July 1947 and that I last saw h/ alive on 3 July 1947

Immediate cause of death Carcinoma of Esophagus — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lowell R. Liberte M. D.
Address Bon Secours Hosp Date signed 7/2/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G53232

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1314

G53232
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 211 S. Castle Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 211 S. Castle Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME John Mokes

3 (b) If veteran, name war No | 3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Petronela
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28-1880

8. AGE: Years 66 67 | Months 11 | Days 8 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Huckster

11. Industry or business own

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Catterne ?
15. Birthplace "

16 (a) Informant Mrs. Mary Hartman
(b) Address 411 S. Madeira St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/8/47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Rd

18 (a) Funeral director Tully & Zeilenga
(b) Address 412 S. Wolfe St

19 (a) 7-8-1947 (Date received by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1947, at 9P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 2 1947 to July 5 1947, and that I last saw him alive on July 5 1947.

	Duration
Immediate cause of death Hypertensive Cardio-Vascular Renal Disease	???
Due to	
Due to	
Other Conditions CEREBRAL HEMORRHAGE	14 YRS 1 DAY

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 229 S. Chester St Date signed 7/7/47 M. D.

G53233

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BC# B82758 / 159

G53233

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address E. Monument St

(c) Hospital or institution: Sinai

(d) Length of stay in hospital or inst. (yrs., mos., or days) 29hrs

(e) Length of stay in Baltimore (yrs., mos., or days) 29hrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto - 24
(If outside city or town limits, write RURAL and give town)

(d) Street No. 521 SAVAGE ST
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Girl Markowitz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	wht.	Infant.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
NB		1	29 hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Nicholas Markowitz

13. Birthplace N.Y.

MOTHER 14. Maiden Name Antoinette Pontch

15. Birthplace Lenna.

16 (a) Informant Antonette Markowitz

(b) Address 521 Savage St.

17 (a) Burial (b) Date thereof 7/7/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Sacred Heart

Location German Hill Rd

18 (a) Funeral director Lilly & Zeluck

(b) Address 403 N. Eden St

19 (a) 7-2-1947 (b)
(Date received by registrar) Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5, 1947, at 11:42 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to July 5 1947, and that I last saw her alive on July 5 1947

Immediate cause of death Prematurity

Due to Premature Labor

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature S. S. Levin

Address Sinai Hosp. Date signed 9/2/47

G53234

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 50

Registered No. G53234

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 415 Illchester Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 415 Illchester Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET LANG McKENNA

3 (b) If veteran, name war ****
3 (c) Social Security Account No. -----

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Owen F. McKenna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years 49 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Lang
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Boehn
15. Birthplace Baltimore, Md.

16 (a) Informant Anna Doenges
(b) Address 526 N. Washington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/8/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location City

18 (a) Funeral director WIEDEFELD AND SON
(b) Address GREENMOUNT AVE & 22ND

19 JUL 7 - 1947 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6th 1947, at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 8 1945 to July 6 1947, and that I last saw h[illegible] alive on July 5 1947

Immediate cause of death: Metastatic Carcinoma of Brain ... Duration 14 days
Due to: Carcinoma of Right Breast ... Duration 2 Years
Due to: Carcinoma of pectus ... Duration 6 Mos
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation Nov 10, 1945
Major findings of operation: Adeno Carcinoma Right Breast.
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William R. Straight M. D.
Address 15 E Preble, M Date signed 7/7/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53235

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G53235

122a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21days
(e) Length of stay in Baltimore (yrs., mos., or days) 21days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Millersville
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Wood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Sadie Mastin
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) 2/11/1871

8. AGE: Years	Months	Days	If less than one day
76	4	21	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name John Wood
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary ?
15. Birthplace Maryland

16 (a) Informant Mrs Sadie Wood
(b) Address Millersville Md

17 (a) Burial (b) Date thereof 7/8/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location RITCHIE HIGHWAY

18 (a) Funeral director JOHN F DENNY Inc
(b) Address 715 LIGHT ST

19 (a) JUL 7 - 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1947, at 1 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-14 1947, to 7-4 1947, and that I last saw h.i.m alive on 7-4 1947.

Immediate cause of death Coronary thrombosis — Duration

Due to

Due to

Other Conditions Recently required left inguinal hernia
(Include pregnancy within 3 months of death)

Date of operation 6-18-47

Major findings of operation: left incarcerated inguinal hernia

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm D. Lynn M. D.
Address University Hosp. Date signed 7-4-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53236

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH ✓ 47c

G53236 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution: South Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 4502 Ritchie Highway (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Charles T. Wampler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Genevieve Wampler
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Sept 28, 1900

8. AGE: Years 46 | Months 9 | Days 7 | If less than one day ____ hr. ____ min.

9. Birthplace Carroll County, Md. (Town, county and state)

10. Usual Occupation
11. Industry or business Seaboard Asphalt Co.

FATHER
12. Name Joseph R. Wampler
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Jane
15. Birthplace Md.

16 (a) Informant wife
(b) Address 4502 Ritchie Highway

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7 9 47 (month) (day) (year)
(c) Cemetery or crematory GLEN HAVEN
Location RITCHIE HIGHWAY

18 (a) Funeral director JOHN F. DENNY, INC
(b) Address 715 LIGHT ST.

19 (a) JUL 7 - 1947 (Date rec'd by registrar) Thurlington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1947 at 1230 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 12 1947 to July 5 1947, and that I last saw h~~im~~ alive on July 5 1947.

Immediate cause of death: Bronchogenic carcinoma of right lung — Duration: 4 mos.
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: Cancer R. right lung

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harold Dillon M. D.
Address So. Balto Gen Hosp Date signed July 5

E-53237

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 171a

E-53237 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Baltimore City Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5201 Eastern Ave.
(If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME John William Pollari

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 7, 1901

8. AGE: Years	Months	Days	If less than one day
45 46	10 11	27	..... hr. ..... min.

9. Birthplace Wyoming
(Town, county, and state)

10. Usual Occupation Machanists Helper

11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Matti Pollari
13. Birthplace Finland

MOTHER
14. Maiden Name Sanna Sijkala
15. Birthplace Finland

16 (a) Informant Mrs. Pauline Kotila
(b) Address 1883 W. 65th St. Cleveland, Ohio

17 (a) Burial (b) Date thereof July 8, 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director Roland L. Fuhrer
(b) Address 2112 Dundalk Ave.

JUL 8 1947 (b) Huntington Williams M.D.
(Date received) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4, 1947, at 10.15 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed skull

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 26/5
(a) Date of injury 7-4-47 at 10 P. M.
(b) Where did injury occur? Dundalk & Fait Ave. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pediastrian struck by St. car

23. Signature Emil H. Kyger M.D.
Medical Examiner.
Date signed 7-5-47

X

G53238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G53238 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Sinai Hosp 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 401 N. Milton Ave.,
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Joseph Haberman

3 (b) If veteran, name war.....
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Anna Haberman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29, 1879

8. AGE: Years	Months	Days	If less than one day
68	-	6	..... hr. ..... min.

9. Birthplace Austria
Shoemaker, Own Business
10. Usual Occupation.....
11. Industry or business

FATHER
12. Name August Haberman
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Anna Haberman-wife
(b) Address 401 N. Milton Ave.,

17 (a) Burial (b) Date thereof 7/9/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road
18 (a) Funeral director Charles E. Schlimmek
(b) Address 2601 E. Madison St.
19 (a) ..... (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

JUL 7 - 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-5-47 19..., at 5:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-5 19 47 to 7-5 19 47, and that I last saw h alive on 7-5 19 47

Immediate cause of death pulmonary edema — Duration

Due to coronary sclerosis, myocardial failure, Arteriosclerosis

Due to.....

Other Conditions Hemorrhage into medulla

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature E. J. Weinman M.D.
Address Sinai Hosp Date signed 7-5-47

C53239 Golley

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. C53239

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2831 Northern Pkwy
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2831 Northern Pkwy. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Ellen Faulkner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Charles P.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1870

8. AGE:	Years	Months	Days	If less than one day
	76	11	8	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Joseph E. Mac Lane
13. Birthplace Md.

MOTHER
14. Maiden Name Mary E. Kinley
15. Birthplace Md.

16 (a) Informant Mrs. Richard E. Charlton
(b) Address 2831 Northern Pkwy.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/ /47 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 JUL 7 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

V. S. 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7th, 19 47 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June / 1947 to July 7 1947, and that I last saw h[illegible] alive on July 7 1947

Immediate cause of death [illegible] Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 5105 Harford Rd Date signed 7/7/47

G53240

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

G53240 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 665 W Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Patrick Murphy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Not given
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace Montana (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Patrick Murphy
13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Randall
15. Birthplace Ireland

16 (a) Informant Patrick Murphy
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JUL 2 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) (State rec'd by registrar) Huddleston Williams M.D.
JUL 7 - 1947

VS. 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 31 1947 to June 29 1947, and that I last saw him alive on June 29 19 47

Immediate cause of death: Carcinoma of Lung Left — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ernest Hug M.D.
M. D.
Address Univ Hosp Date signed 7-2-47

G53241

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Blk B 82319

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered G53241

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days) "

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1604 Ward Street (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Baby Boy Griffin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-24-47 12:55 A

8. AGE: Years | Months | Days | If less than one day 9 hr. 45 min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Dan Griffin
13. Birthplace Hazlehurst, Miss.

MOTHER 14. Maiden Name Maybelle Tilley
15. Birthplace Hazlehurst, Miss.

16 (a) Informant Maybelle Griffin
(b) Address 1604 Ward Street

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JUL 3 1947

18 (a) Funeral director Commissioner of Health
(b) Address
JUL 7 - 1947 Huntington Williams, M.D.
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-24-47 19 . at 9:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-24-47 19 . to 6-24-47 19 .
and that I last saw h— alive on 6-24 19 47.

Immediate cause of death Fetal atelectasis | Duration

Due to P

Due to Prematurity

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Redwood & Greene Sts Date signed 6-24-47

X

G53242

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G53242

160a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun Sts
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 18 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4009 Taylor Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Haman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/1/47

8. AGE: Years | Months | Days | If less than one day: 18 hr. 30 min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Reed Haman
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Margaret Wallace
15. Birthplace Baltimore, Maryland

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JUL 3 1947

18 (a) Funeral director Commissioner of Health
(b) Address
7-1947 Kenneth Williams MD
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2, 1947, at 1:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1/47 19 to 7/2/ 1947 and that I last saw him alive on 7/2/ 1947

Immediate cause of death: Respiratory Failure — Duration

Due to Congenital Atelectasis

Due to Intracranial Hemorrhage

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. P. Brinkshank

Address Franklin Square Hosp. Date signed 7/2/47

VS 150

G53243 Bl#G-82491

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157a

G53243 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edmondson Avenue
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 712 W. Barre St #30 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Heakin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/6/47

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Oliver Heakin
13. Birthplace Cumberland Md

MOTHER
14. Maiden Name Margie Pauline Cantrell
15. Birthplace Portsmouth Ohio

16 (a) Informant Mrs Margie Heakin
(b) Address 712 W Barre St #30

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JUL 3 1947
18 (a) Funeral director Commissioner of Health
(b) Address
19 (a) JUL 7 - 1947 (Date received by registrar) Huntley Yost Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 1947, at 5 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-26 1947 to 6-29 1947 and that I last saw h alive on 6-29 1947

Immediate cause of death: Bronchopneumonia
Due to: Congenital Abnormalities
Due to:
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph L. Drucker M. D.
Address University Hosp - Date signed 7-2-47

G53244

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No. G53244

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5301 Pennington ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5301 Pennington ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ollie PEARSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Widow
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JUL 7 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) 1441 (Date filed by registrar) Huntington Mitchell, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1947 at 10 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute dilatation of heart
Acute pulmonary edema.
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 6/17/47

X

G53245

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √95c

Registered No. G53245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 5 W
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL. Add give town)
(d) Street No. 265 Colvin Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FISHER RILEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Male | 5 Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years 45+ | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JUL 7 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JUL 7 - 1947 (Date rec'd by registrar) (b) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH June 14, 1947 at 9 05 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute dilatation of heart

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 6/16/47

C53246

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Register No. C53246

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1710 Patapsco St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23'
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and name of town)
(d) Street No. 1710 Patapsco St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie M. Carper

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: William Carper
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23, 1870

8. AGE: Years 77 | Months 9 | Days 13 | If less than one day: hr. min.

9. Birthplace Martinsburg W. Va
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name —— Miller
13. Birthplace Martinsburg W. Va

MOTHER
14. Maiden Name Dent Keller
15. Birthplace Dept Penn

16 (a) Informant Mildred Faber
(b) Address 1710 Patapsco St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 9, 1947 (month) (day) (year)
(c) Cemetery or cemetery Mt Olivet Cem
Location Balto Md

18 (a) Funeral director C. Percival Evans
(b) Address 1210 Dolphin St

19 JUL 7 - 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6, 1947, at 10:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1947 to July 6, 1947, and that I last saw her alive on July 1947.

Immediate cause of death: Hypertensive cardio vascular disease — Duration: 2

Due to —

Due to —

Other Conditions: None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Deiler M. D.
Address 226 Hanover St. Date signed 7/7/47

X

G53247

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G53247
Registered No.

MARGIN RESERVED FOR BINDING.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2205 Booth Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2205 Booth Street (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) **FULL NAME** James Andrew Ryan

3 (b) If veteran, name war None

3 (c) Social Security Account No. 216-14-8279

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Regina Ryan

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Sept 14, 1883

8. AGE: Years 63 | Months 9 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business General Electric Supply Co.

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (c) Informant Regina Ryan
(b) Address 2205 Booth Street

17 (a) Burial (b) Date thereof 7-10-47 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Our Cathedral
Location Baltimore, Maryland

18 (a) Funeral director George L. Schwab
(b) Address 2101 Kirkwood Ave.

JUL 8 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1947, at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1947 to July 1947, and that I last saw h[illegible] alive on June 25 1947.

Immediate cause of death Pulmonary TB — Duration 8 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature C. P. Sulewski

Address 1910 N Wall St. Date signed 7/3/47 M. D.

C53248

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. C53248

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1914 W Pratt St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1914 W Pratt St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME John J Gannon

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-311

4 Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 14 1903

8. AGE: Years 43 | Months 7 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Waiter Hotel

FATHER 12. Name Patrick J Gannon

13. Birthplace Ireland

MOTHER 14. Maiden Name Maria E Carr

15. Birthplace Ireland

16 (a) Informant Thomas J Gannon

(b) Address 3236 Clifton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/8/47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore Md

18 (a) Funeral director Fulton & Cook Inc

(b) Address 2107 Pont St

JUL 8 - 1947 (Date rec'd by Registrar) (b) Huntington Williams Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1947, at 3:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1947, to July 4 1947 and that I last saw h/m alive on 3 July 1947.

Immediate cause of death Pulmonary Hemorrhage — Duration 20 min

Due to Chronic tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H H Baylus M.D.

Address 1600 Watkins Ave Date signed 7 July 47

G53249

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 1318

G53249 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 24 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna (b) County
(c) City or town Hazleton (If outside city or town limits, write RURAL and give town)
(d) Street No. 141 N. Church Street. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel A. Cohn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife. Nettie Cohn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/13/97

8. AGE: Years	Months	Days	If less than one day
49	10	24	hr. 26 min.

9. Birthplace Pennsylvania Hazleton (Town, county, and state)

10. Usual Occupation Manager Cohn Hardware

11. Industry or business Company.

FATHER
12. Name Jacob Cohn
13. Birthplace Russia

MOTHER
14. Maiden Name Rachael Glass
15. Birthplace Russia

16 (a) Informant Nettie Cohn
(b) Address 141 N. Church St Hazelton Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-9-47 (month) (day) (year)
(c) Cemetery or crematory Agudas Israel
Location Hazelton Pa

18 (a) Funeral director Jack Lewis Inc
(b) Address 1009 E Balto St
(c) Date received by registrar JUL 8 - 1947 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1947, at 5:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947 to July 8 1947 and that I last saw h. im alive on July 7 1947.

Immediate cause of death Uremia — Duration

Due to Chronic glomerular Nephritis

Due to Hypertensive Cardio-Vascular Disease

Other Conditions Uremic Peri-carditis.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry B. Leath M.D.
Address Mercy Hospital signed 7/8/47

X

G53250

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH (55)

G53250 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 51st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 180 days
(e) Length of stay in Baltimore (yrs., mos., or days): 180 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: NY (b) County:
(c) City or town: Brooklyn (If outside city or town limits, write RURAL and give town)
(d) Street No.: 536 Senator St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: Norway

3 (a) FULL NAME: Alf Magdal Andersen

3 (b) If veteran, name war: --

3 (c) Social Security Account No.: 094-05-3944

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 18, 1875

8. AGE: Years: 71 Months: 8 Days: 18 If less than one day: hr. min.

9. Birthplace: Norway (Town, county, and state)

10. Usual Occupation: Watchman

11. Industry or business: Seafarer

FATHER
12. Name: Peter Andersen
13. Birthplace: Norway

MOTHER
14. Maiden Name: Catherine ?
15. Birthplace: Norway

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof July 8-1947 (month) (day) (year)
(c) Cemetery or crematory: Green Mount
Location: Baltimore, Maryland

18 (a) Funeral director: Burgee Funeral Home
(b) Address: 321 Fells Road

19 (a) 8-1947 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 6 1947, at 3:25A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 7 1947 to July 6 1947 and that I last saw him alive on July 6 1947.

Immediate cause of death: (1) Carcinoma involving pyriform sinus right vocal cord area and muscles of ~~Due to~~ adjacent neck — Duration: 9 mos.
(2) Partial occlusion of epi- ~~Due to~~ glottis and esophagus — Duration:
(3) Bronchopneumonia, bilaterally — Duration: About 1 wk.
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon 7/7/47
Address: Clinical Director Date signed

X

G53251

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 61

Registered No. G53251

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 13-6
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3512 Lakewood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MRS. CORA V. RAMSBURG
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced. MARRIED
6 (b) Name of husband or wife Lewis B Ramsburg
6 (c) If alive, give age 77 years
7. Birth date of deceased (mo., day, yr.) Sept 2 1874
8. AGE: Years 72 73 Months 9 Days 29 If less than one day ..... hr. ..... min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business
FATHER 12. Name James P. Dorsey
13. Birthplace Md.
MOTHER 14. Maiden Name Emma J. Hall.
15. Birthplace Md.
16 (a) Informant Lewis B. Ramsburg.
(b) Address 3512 Lakewood Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 9 1947 (month) (day) (year)
(c) Cemetery or crematory Moreland Park. Location Taylor Ave.
18 (a) Funeral director Hepburn & Donovan
(b) Address 3615-17 Liberty Ave.
19 (a) Date received by local registrar JUL 8 1947 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1947, at 12:58 P M
21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1947, to July 6 1947, and that I last saw her alive on July 6 1947.

	Duration
Immediate cause of death Respiratory failure	
Due to Acidosis	
Due to Diabetic Coma	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature John Gordon Monash M.D.
Address Md. Gen. Hosp. Date signed July 6, 1947

X

G53252

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G53252
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Catons Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 14 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Frederick
(c) City or town Thurmont.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rt # 2
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nancy M Little

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/22/46

8. AGE: Years | Months: 9 | Days: 5-14 | If less than one day: hr. min.

9. Birthplace Maryland.
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business —

FATHER
12. Name Elias Brawner
13. Birthplace Maryland.

MOTHER
14. Maiden Name Catherine Little
15. Birthplace Maryland

16 (a) Informant Catherine Little
(b) Address Thurmont, Md

17 (a) Burial (b) Date thereof July 9-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt St Marys Cem
Location St Anthonys Emmitsburg Md

18 (a) Funeral director M. L. Creadysupton
(b) Address Thurmont Md

19 (a) (b) Huntington Williams MD
Date received by local registrar JUL 8 1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1947, at 5:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/22 1947, to 7/6 1947, and that I last saw h[illegible] alive on 7/6 1947.

Immediate cause of death Cardiac failure - Malaria
Acute pneumonia
Due to Lymphosarcoma

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H Williams MD
Address Thurmont Date signed 7/7/47
M. D.

G53253

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 97

Registered No. G53253

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hampnett Ave.
(c) Hospital or institution:
Pineridge Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2329 Calverton Hgts. Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLARK K. STRASBURG

3 (b) If veteran, name war --

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Margaret M. Strasburg

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1870

8. AGE: Years 76 | Months 8 | Days 9 10 | If less than one day ... hr. ... min.

9. Birthplace Staunton, Va.
(Town, county, and state)

10. Usual Occupation Printer - retired

11. Industry or business Baltimore News-Post

FATHER
12. Name David E. Strasburg
13. Birthplace Goshen, Va.

MOTHER
14. Maiden Name Emma J. Kite
15. Birthplace Elkton, Va.

16 (a) Informant Mr. E. H. Appleby
(b) Address 2506 Halcyon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/9/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto., Md.

19 (a) Date received JUL 8 1947 (b) Registrar Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6, 1947, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947, to July 8 1947, and that I last saw h[illegible] alive on July 5 1947.

Immediate cause of death	Duration
Cardiac failure	4 days
Due to Arterio-sclerosis	1 yrs
Due to Senile debility	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. S. French 2nd M. D.
Address 2370 Arunah Ave. Date signed 7/7/47

G53254

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G53254

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2900 Manhattan Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-19
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2900 Manhattan Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELMA AURELIA KLEIN

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Gustav Klein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Spet. 23, 1883

8. AGE: Years	Months	Days	If less than one day
63	9	12	hr. min.

9. Birthplace: Balto., Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Edward J. Schott
13. Birthplace: unknown

MOTHER
14. Maiden Name: Marie Reese
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mr. Gustav Klein
(b) Address: 2900 Manhattan Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/8/47 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by reg'r) (b) Registrar

JUL 8 - 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5, 1947 at 3:50p M

21. I certify that death occurred on the date above stated; that I attended deceased from July 4 1947 to July 5 1947 and that I last saw h[er] alive on July 5 1947

Immediate cause of death: Coronary Thrombosis — Duration: 7/4/47
Due to:
Due to:
Other Conditions: Diabetes Mellitus — 1944
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: John D. Gilbert M. D.
Address: 803 Park Heights Ave Date signed 7/7/47

94a

G53255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G53255 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1738 Carswell St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-7
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1738 Carswell St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH DAYHOOF PIEPER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Frank N. Pieper
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) Mar. 4, 1877

8. AGE: Years	Months	Days	If less than one day
70	4	2	hr. min.

9. Birthplace Frederick Co., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John T. Dayhoof
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine Schneider
15. Birthplace Md.

16 (a) Informant Mr. Frank N. Pieper
(b) Address 1738 Carswell St.

17 (a) Burial (b) Date thereof July 9, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Pk.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date rec'd by Registrar July 8 - 1947 (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6, 1947 at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1920 to July 6 1947.
and that I last saw h alive on July 5 1947.

Immediate cause of death — Duration

Due to Hypertension Cer. Vascular Renal — 3 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Fritz S Krueger M. D.
Address 2700 Harford Rd Date signed July 7 '47

653256

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓83a

G53256
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Gen'l. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1934 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME OAKLAND DENNIS RAYMO

3 (b) If veteran, name war: none
3 (c) Social Security Account No. 220-14-8308

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/17/1903

8. AGE: Years 44 | Months 0 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Guard
11. Industry or business Race Association

FATHER
12. Name Douglas Raymo
13. Birthplace N. Y.

MOTHER
14. Maiden Name Daisy Fogle
15. Birthplace Frederick Co., Md.

16 (a) Informant Mrs. Daisy Raymo
(b) Address 1934 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/10/47 (month) (day) (year)
(c) Cemetery or crematory Mountain View
Location Union Bridge, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 JUL 8 - 1947 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1947, at 4:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947, to July 7 1947, and that I last saw him alive on July 7 1947.

Immediate cause of death Subarachnoid Hemorrhage — Duration

Due to Congenital Aneurysm

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Hemorrhage of basal brain

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman Levin, M.D.
Address West Balto. General Hospital Date signed July 7, 47

G53257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

DR FREY 93D

Registered No. G53257

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 608 Dolphin St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 ?
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 608 Dolphin St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma L. Robinson.

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race col | 6 (a) Single, married, widowed, or divorced. ?

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 5-20-1882

8. AGE: Years 65 | Months 2 1 | Days 15 | If less than one day hr. min.

9. Birthplace Maryland. (Town, county, and state)

10. Usual Occupation House Work

11. Industry or business

FATHER 12. Name Joseph Jones
13. Birthplace Md

MOTHER 14. Maiden Name Elizabeth ?
15. Birthplace Md

16 (a) Informant Howard Robinson
(b) Address 529 Wilson St

17 (a) Mt. Auburn Cem (Burial, cremation, or removal) (b) Date thereof 7 9 47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 916 Penna. ave.

19 (a) JUL 8 1947 (Date rec'd by registrar) Huntington Williams M.D.

VS .150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1947, at 9.40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 4 19 47 to July 5 19 47 and that I last saw h er alive on July 6 19 47.

Immediate cause of death Carded Vascular Disease — Duration 1 yr ?

Due to Broken Compression — 3 months

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E William Frey M. D.

Address 928 Penna Ave Date signed 7/7/47

C53258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C53258

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 740 W. Fairmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-2
(e) Length of stay in Baltimore (yrs., mos., or days) 15yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 740 W. Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK RASPEBERRY

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/24/1895

8. AGE: Years	Months	Days	If less than one day
52	1	10½	hr. min.

9. Birthplace N.C.
(Town, county, and state)
10. Usual Occupation Huckster
11. Industry or business

FATHER
12. Name Nathan Raspeberry
13. Birthplace N.C.

MOTHER
14. Maiden Name Jane Williams
15. Birthplace N.C.

16 (a) Informant Mary Ruffin(Sister)
(b) Address 407 N.Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/8/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N.Carrollton Ave

JUL 8 - 1947 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/5/47 19 , at 8.00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/15/47 to 7/5 1947
and that I last saw h[illegible] alive on 7/5/47

Immediate cause of death (a) Congestive Heart Failure — Duration 5 weeks
Due to (b) Hypertension
Due to (c) Chronic Interstitial Disease
Other Conditions None

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. W. Redding, M.D.
Address [illegible] Date signed 7/8/47

G53259

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓183

Registered No. G53259

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 19-2 D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 13 N. Mount St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HERBERT L. CARTER

3 (b) If veteran, name war: W.W.#2

3 (c) Social Security Account No. 218-07-0716

4. Sex: Male

5. Color or race: colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Martha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/30/1916

8. AGE: Years 30 | Months 9 | Days 4 | If less than one day ..... hr. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Stevedore

11. Industry or business

FATHER
12. Name: Frank Carter
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Ruth Rowe
15. Birthplace: Baltimore, Md.

16 (a) Informant: Martha Carter (Wife)
(b) Address: 13 N. Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/8/47 (month) (day) (year)
(c) Cemetery or crematory: Balto. National
Location: Baltimore, Md.

18 (a) Funeral director: Charles G. Cooper
(b) Address: 510-12 N. Carrollton Ave

19 JUL 8 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4, 1947, at 1.25 P.M.

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-4-47 1 p. 4/1 M.
(b) Where did injury occur? Pier #1 Pratt St. Baltimore, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury: Fell overboard

23. Signature: Earl L. Royster Medical Examiner. M.D.
Date signed 7-5-47

G53260

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G53260

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1643 Ellamont St.,
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1643 Ellamont St., (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha M. Krout

3 (b) If veteran, name war ----
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Adam C. Krout
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1856

8. AGE: Years	Months	Days	If less than one day
90	9	15	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Conrad Switzer
13. Birthplace Pa.

MOTHER
14. Maiden Name Margaretta Firoved
15. Birthplace Pa.

16 (a) Informant Mrs. William J. Culver
(b) Address 1643 Ellamont St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-9-47 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore, Md.

18 (a) Funeral director D. Howard Strong
(b) Address 3207 W. North Ave.
(c) Date received by registrar JUL 8 - 1947 Registrar Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7, 1947, at 2.15 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to July 7th 1947, and that I last saw her alive on July 7 1947.

Immediate cause of death	Duration
Coronary Sclerosis	
Due to Senility Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address 3033 W. North Ave Date signed 7/7/47 M. D.

G53261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G53261

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1453 N. Carey St
(c) Hospital or institution: 15-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) Lifetime
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1453 N Carey St (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Maggie Rass.

3 (b) If veteran, name war: V
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: Col
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 12/27/1900

8. AGE: Years 46 | Months 47 | Days 6 | If less than one day ..... hr. ..... min. | 9

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Seamstress
11. Industry or business Apt

FATHER
12. Name Thomas Rass.
13. Birthplace Baltimore

MOTHER
14. Maiden name Julia Bentley
15. Birthplace Baltimore

16 (a) Informant Julia Rass
(b) Address 1453 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 9-47 (month) (day) (year)
(c) Cemetery or crematory Mt Lebanon
Location Va Brooke

18 (a) Funeral director Va Brooke
(b) Address 1463 N. Carey St.

(a) 8-1947 (Date rec'd by local reg.) (b) Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1947, at 1035 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to July 5/47, and that I last saw h[illegible] alive on July 5 1947.

Immediate cause of death: Carcinoma Liver + Gall Bladder — Duration: about 1 yr.
Due to .....
Due to .....
Other Conditions .....

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....

23. Signature Henry C. Hammond M.D.
Address 1923 W Mt Royal Ave Date signed July 8/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53262

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

Registered No. G53262

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 836 N. Augusta Ave.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 836 N. Augusta Ave., (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie E. Johnson

3 (b) If veteran, name war ----

3 (c) Social Security Account No. ----

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or ~~wife~~ Andrew L. Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1866

8. AGE: Years 81 | Months 4 | Days 12 | If less than one day hr. min.

9. Birthplace Harford Co., Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Wm. Henry Whitten
13. Birthplace Ireland

MOTHER
14. Maiden Name Elizabeth Jane Taylor
15. Birthplace Harford Co., Md.

16 (a) Informant Mrs. Paul A. Paul
(b) Address 836 N. Augusta Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-10-47 (month) (day) (year)
(c) Cemetery or crematory Abingdon
Location Harford Co., Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.

JUL 8 - 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7, 1947, at 2.45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 1946 to 19 , and that I last saw her alive on 7 July 1947.

Immediate cause of death Circulatory failure — Duration

Due to Arteriosclerotic heart disease years
with auricular fibrillation

Due to

Other Conditions Hypostatic pneumonia 10 days
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Douglas Lockard M. D.

Address 22 Valdera St Date signed 8 July 47

X

G53263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G53263

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 919 N. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Lucie Elliott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Luke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 7 1899

8. AGE: Years: 47 | Months: 1 | Days: 28 | If less than one day: hr. min.

9. Birthplace: New Bern, N. C. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Nathaniel Whitman
13. Birthplace: High Pt. N. C.

MOTHER
14. Maiden Name: Unknown
15. Birthplace

16 (a) Informant: Mr. Luke Elliott
(b) Address: 919 N. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: July 8, 1947 (month) (day) (year)
(c) Cemetery or crematory: Family Lot
Location: New Bern, N. C.

18 (a) Funeral director: Mrs. Edw. A. Holland
(b) Address: 1651 Druid Hill Ave.

JUL 8 - 1947 (Date received) Washington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7/4/47, 19, at 2.50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/18/47 to 7/4/47.
and that I last saw her alive on 7/4/19 47.

Immediate cause of death: Ca of large bowel.

Due to:

Due to:

Other Conditions: Arteriosclerotic gangrene of foot.
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: None

of autopsy: None

Duration: Unk.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: D. E. B. Higgins, M. D.
Address: Provident Hosp. Date signed: X 7/7/47

G53264

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure age is especially important.

G53264

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G53264 / 132

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Home for the Aged Poor
(c) Hospital or institution: 1200 Valley St
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Schneider

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Mo.	W.	W

6 (b) Name of husband or wife Elisabeth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1872

8. AGE: Years	Months	Days	If less than one day
74	9	24	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Wm. Schneider
13. Birthplace

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Lillie Fisher / Jno Poore
(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 10, 1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rife Wingfield
(b) Address 900 East Biddle St

(c) (Date received by registrar) JUL 8 1947 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1947, at 1 a.M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw him alive on July 7 1947.

Immediate cause of death Uremia — Duration

Due to Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Carol Fisher M. D.
Address 1827 N. Mad. St. Date signed 7/8/47

G53265

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH V 131a

G53265 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland
(c) Hospital or institution: Sinai Hospital
6/24/47 → 7/7/47 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1224 Ainsworth St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Mammie Eck

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17, 1873

8. AGE: Years	Months	Days	If less than one day
74	1	20	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Belt
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Emma Treadway
15. Birthplace Baltimore, Md

16 (a) Informant Melvin Eck
(b) Address 3125 Cliftmont Ave

17 (a) Burial (b) Date thereof 7/10/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Milton & Rose Sts.

18 (a) Funeral director Howard W. Blight Jr.
(b) Address 6009 Harford Road

(a) JUL 8 1947 (b) Huntington Williams, M.D.
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1947, at 3:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 29 1947 to July 7 1947, and that I last saw her alive on July 7 1947.

Immediate cause of death	Duration
Uremia	4 days
Due to Arterialar nephro sclerosis of kidneys	4 yrs.
Due to	
Other Conditions Hypertensive heart disease	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R E Cohnberg M. D.
Address Sinai Hospital Date signed 7/7/47

X

G53266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G53266 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 930 E. Biddle St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 930 E. Biddle St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Barbara A. Engelhart

3 (b) If veteran, name war

3 (c) Social Security Account No. ✓

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Jos Engelhart

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 10, 1879

8. AGE: Years 68 | Months 5 | Days 28 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name John Behringer

13. Birthplace Germany

MOTHER 14. Maiden Name Smith

15. Birthplace Germany

16 (a) Informant Mrs. Engelhart

(b) Address 930 E. Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 10, 1947 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore

18 (a) Funeral director Rita Wiedefeld

(b) Address 900 East Biddle St.

JUL 8 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1947, at 3:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1946 to July 1947 and that I last saw her alive on 6 July 1947.

Immediate cause of death Pneumonia — Duration 1 day

Due to Cerebral Vascular Accident — 3 wks

Due to Arteriosclerosis — 5 yrs

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [signature] M.D.

Address 2857 Hartford Date signed July 8 47

G53267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G53267

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 148 Mc. Phail St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 148 Mc Phail St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Sophie Heim.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife Julius Heim. 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6-1871

8. AGE: Years 76 | Months 3 | Days 0 | If less than one day hr. min.

9. Birthplace Germany. (Town, county, and state)

10. Usual Occupation Housework.

11. Industry or business

FATHER
12. Name John Jakel.
13. Birthplace Germany.

MOTHER
14. Maiden Name Katherine Rettenburg.
15. Birthplace Germany.

16 (a) Informant Mrs. Fred Hebron
(b) Address Long Point N.J.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof July 9/47. (month) (day) (year)
(c) Cemetery or crematory Western Cemetery.
Location

18 (a) Funeral director Charles J. Schwab.
(b) Address 3512 Frederick Ave.

19 (a) JUL 8 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July - 6th. 1947 at 4.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 6 1947 to July 6 1947, and that I last saw h[illegible] alive on July 6 1947.

Immediate cause of death Arteriosclerotic Heart Disease — Duration ?

Due to Generalized arteriosclerosis ?

Due to

Other Conditions Infection, stasis 8 wks.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. B. Schreiber M. D.
M. D.
Address 5 & S. Fulton Ave Date signed 7-8-47

VS 150

C53268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47a

Register C53268

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 210 days
(e) Length of stay in Baltimore (yrs., mos., or days) ---

2. USUAL RESIDENCE OF DECEASED:
(a) State None (b) County
6 (c) City or town None
(If outside city or town limits, write RURAL, and give town)
(d) Street No. None
(If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country Great Britian

3 (a) FULL NAME William Christie Abbie

3 (b) If veteran, name war ---
3 (c) Social Security Account No. ---

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single(?)
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 2, 1886
8. AGE: Years 61 | Months - | Days 5 | If less than one day hr. min.
9. Birthplace Uitenhage, South Africa (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Seafarer

FATHER
12. Name Andrew Abbie
13. Birthplace Scotland

MOTHER
14. Maiden Name Jennie Christie
15. Birthplace Scotland

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 9-47 (month) (day) (year)
(c) Cemetery or crematory Govans Presbyterian
Location Balto Md
18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave
19 JUL 8 - 1947 Huntington Williams, M.D. (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1947, at 1:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 9 1946 to July 7 1947 and that I last saw him alive on July 7 1947.

Immediate cause of death: Carcinoma of larynx with cervical and pelvic metastases — Duration: 1 year
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 7/7/47

VS 150

G53269

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124 B

Registered No. G53269

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 Division St 19-1
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 MON 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 582

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 521 Barnard St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country None

3 (a) FULL NAME Richard Stewart

3 (b) If veteran, name war: yes World War I
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: N
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Laura Stewart
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) 2/9/1895

8. AGE: Years 52 Months 5 Days 4 1 22 If less than one day hr. min.

9. Birthplace Baltimore MD. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business None

FATHER
12. Name Moses Stewart
13. Birthplace Howard County

MOTHER
14. Maiden Name Sarah Woodland
15. Birthplace St Marys County

16 (a) Informant Sister, Madelina
(b) Address 1515 Mosher St Hilton

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-9-1947 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 JUL 8 - 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/3 1947 at 10 00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/29 1947 to 7/3 1947 and that I last saw him alive on July 3 1947.

Immediate cause of death: Hemorrhage from Ruptured Esophageal Varices — Duration
Due to: Cirrhosis of Liver
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
Means of injury

*23. Signature J. Preston Grant
Address Provident Hosp. Date signed 7/5/47 M. D.

G53270

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

G53270 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1017 W. Lexington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1017 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dora Johnson.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 8, 1897

8. AGE: Years	Months	Days	If less than one day
50	5	28	hr. min.

9. Birthplace Carroll County Md.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name James Seymour
13. Birthplace Carroll County Md.

MOTHER
14. Maiden Name Alice Thomas
15. Birthplace Carroll County Md.

16 (a) Informant Hattie Taylor
(b) Address 1017 W. Lexington St
17 (a) Burial (b) Date thereof 7-8-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Star
Location Catonsville, Md.
18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St
19 (a) JUL 8 1947
(Date rec'd by registrar) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/5/47 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/2/47 to 7/5/47 19 , and that I last saw h alive on 7/5/47 19 .

Immediate cause of death Cardiac failure

Due to Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Wm E Foster M. D.
Address 401 E Edmondson Date signed 7/6/47

G53271

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √131a

G53271 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1108 N. Washington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1108 N. Washington St
(If rural give location)
(e) Citizen of foreign country? h.c. (Yes or No)
If yes, name country

3 (a) FULL NAME Wise Washington

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-12-9976

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Mary

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Sept 5, 1887

8. AGE: Years: 60 | Months: 10 | Days: - | If less than one day: hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Martha Simpson
(b) Address 1108 N. Washington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 8/47 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem.
Location A. A. County Md

18 (a) Funeral director Mrs. Pott & Kellenbach
(b) Address 1129 N. Carolina Baltimore Md

19 (a) DEC 8 1947 (b)
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5, 1947, at 9:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1947, to July 5 1947, and that I last saw him alive on July 2 1947.

Immediate cause of death: Hypertensive-cardio renal disease — Duration: 7

Due to: Arteriosclerosis — Duration: 7

Due to: —

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation: h.m.a
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. W. Thompson
Address 1422 E. Pratt St Date signed M 7 D 5/47

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53272

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 50

Registered No. G53272

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1414 Richardson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1414 Richardson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Walker

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Albert Walker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 6, 1872

8. AGE: Years	Months	Days	If less than one day
75	4	1	hr. min.

9. Birthplace Ger. (Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Family
(b) Address 1414 Richardson St.

17 (a) B (Burial, cremation, or removal) (b) Date thereof 7/10/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn, Md.

18 (a) Funeral director James L. Gill Sons
(b) Address 130 S. Howard St.

19 (a) Date received JUL 8 1947 (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/7 1947, at 11 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1947 to 7/3 1947, and that I last saw her alive on 9/3 1947.

Immediate cause of death	Duration
(a) Cerebral Thrombosis	indefinite
Due to (b) Arteriosclerosis	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Not Performed
Major findings of operation: N/A 1946
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. S. Ellis M. D.
Address 107 E. West St. Date signed 7/7/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53273 BC# B-5 7868

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G53273

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Lombard st
(c) Hospital or institution: Univ of Md. Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1129 Parish St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME MARY MORGAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/22/41

8. AGE: Years	Months	Days	If less than one day
	9	13	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John H Morgan
13. Birthplace N.C.

MOTHER
14. Maiden Name Mary Butler
15. Birthplace Md.

16 (a) Informant Elizabeth Butler
(b) Address 1129 Parish St

17 (a) Burial (b) Date thereof 7/9/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Presstman St

19 (a) JUL 8 1947 Huntington Md. Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/5 19 . at 2:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1947, to 7/5 1947 and that I last saw h[illegible] alive on 7/5 1947.

Immediate cause of death	Duration
cardio-resp collapse	
Due to tuberculous meningitis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: t.b. meningitis, miliary t.b

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature Joseph Shear M.D.
Address Univ Hosp Date signed 7/[illegible]/47

G53274

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47c

G53274 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st Sts.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 115 days
(e) Length of stay in Baltimore (yrs., mos., or days): ---

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: Anne Arundel
(c) City or town: Churchton (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME: Mark Hanna Gross

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	Single

6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 4, 1903

8. AGE: Years	Months	Days	If less than one day
44	--	2	hr. min.

9. Birthplace: Churchton, Md. (Town, county, and state)
10. Usual Occupation: Cook
11. Industry or business: Seafarer

FATHER
12. Name: Benjamin Gross
13. Birthplace: Churchton, Md.

MOTHER
14. Maiden Name: Ida ?
15. Birthplace: Md.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Shadyside (Burial, cremation, or removal) (b) Date thereof 7/9/47 (month) (day) (year)
(c) Cemetery or crematory: Burial
Location: Md. Shadyside

18 (a) Funeral director: Reg. D. Nelson
(b) Address: 1363 Breesteman St.

19 JUL 8 - 1947 (Date rec'd by registrar) (c) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 6 1947, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 13 1947 to July 6 1947, and that I last saw him alive on July 6 1947.

Immediate cause of death: Carcinoma, bronchogenic left lung with extension to regional lymph nodes. — Duration: UNKNOWN
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon 7/7/47 D.
Address: Clinical Director Date signed

LOHAN

G53275

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47F

G53275 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baldwin (If outside city or town limits, write RURAL and give town)
(d) Street No. Green Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard J. Lohan

3 (b) If veteran, name war: World War Army
3 (c) Social Security Account No. 213-07-157
Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Ruth Lohan
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) 2-8-97

8. AGE: Years	Months	Days	If less than one day
50	4	28	— hr. — min.

9. Birthplace: England (town, county and state)
10. Usual Occupation: Farm Laborer
11. Industry or business: Farming
FATHER 12. Name: Joseph Vincent Lohan
13. Birthplace: England
MOTHER 14. Maiden Name: Catherine Lowers
15. Birthplace: England
16 (a) Informant
(b) Address: JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: July 9th 1947 (month) (day) (year)
(c) Cemetery or crematory: Greenmount
Location: York Avenue
18 (a) Funeral director: Bertrand Lee
(b) Address: 2224 N. Charles St.
JUL 8 - 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-6-1947 at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-20 1947 to 7-6-1947 and that I last saw h[illegible] alive on 7-6-1947.

Immediate cause of death	Duration
Myocardial infarction d.	1 hr.
Arteriosclerosis coronary aa	3 mos.
Due to Progressive exhaustion and respiratory embarrassment	8 mos.
Due to Mediastinal neo-plasm.	over
Other Conditions Pleural effusion	

(Include pregnancy within 3 months of death)
Date of operation 7-3-47.
Major findings of operation: Metastasis to cervical nodes.
of autopsy: 1

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Thomas E. Van Metre JR M. D.
Address U Hopkins Hosp Date signed 7-7-47

VS 150

X

G53276

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G53276

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1716 Braterwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-5
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1716 Braterwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lloyd Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Married

6 (b) Name of husband or wife Minnie Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4 1887

8. AGE: Years	Months	Days	If less than one day
60 yrs.	-	2	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name "Unknown"
13. Birthplace

MOTHER
14. Maiden Name Louise Wilson
15. Birthplace Maryland

16 (a) Informant Minnie Thomas
(b) Address 1716 Braterwood Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof July 8 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Anne Arundel County

18 (a) Funeral director Turner Undertaking Co.
(b) Address 1417 E. Fredrick St

19 (a) Filed by registrar Huntington Williams M. D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6, 1947, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 - 1946 to July 5 1947 and that I last saw h- alive on July 5 1947.

Immediate cause of death: Cerebral Hemorrhage — Duration: 4 days
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 324 [illegible] Date signed 7-6-47

G53277

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

G53277

Registered No.

MARGIN RESERVED FOR BINDING

The Every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green Sts.
(c) Hospital or institution: University Hospital 20

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 28 S. Ellamont St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Diffatta

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Salvatore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/3/1871

8. AGE: Years 76 | Months 5 2 | Days 3 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name ?
13. Birthplace Italy

MOTHER
14. Maiden Name Deparancesca
15. Birthplace Italy

16 (a) Informant Mr. Joseph Marsanto
(b) Address 28 South Ellamont St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/10/47 (month) (day) (year)
(c) Cemetery or crematory
Location Cathedral

18 (a) Funeral director Thomas J. Kenny Inc.
(b) Address 1600 Hollins St.

19 (a) Filed JUL 8 1947 Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6, 1947 at 10:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/21 1947 to 7/6 1947 and that I last saw her alive on 7/6 1947

Immediate cause of death: Carcino-respiratory failure — Duration: 1½ days

Due to: Carcino-vascular accident — Duration: 1 day

Due to: Hypertension — Duration: Unknown

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. J. Phillips, M.D. M. D.
Address University Hosp. Date signed 7/6/47

VS 150

C53278 Dr. Harbold

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 93

Registered No. C53278

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3005 Echodale Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3005 Echodale Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William J. Gill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Anne M. Gill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 8, 1908

8. AGE: Years	Months	Days	If less than one day
38	10	29	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Gill
13. Birthplace Md.

MOTHER
14. Maiden Name Gertrude Richard
15. Birthplace Md.

16 (a) Informant Mrs. Anne M. Gill
(b) Address 3005 Echodale Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/11/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 JUL 8 1947 (b) Huntington Williams, M.D. Registrar
Received by Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7th, 1947 at 6:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 4 1947 to July 7 1947 and that I last saw h-im alive on July 5 1947.

Immediate cause of death: Coronary Thrombosis — Duration: Sudden
Due to Coronary sclerosis
Due to Hypertension Cardio-vascular Disease
Other Conditions Xanthoma Disseminata

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. V. Harbold
Address 4706 Harford Road Date signed 7/8/47 M. D.

G53279

JL - 111916

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G53279

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 h
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 4
(If outside city or town limits, write RURAL and give town)
(d) Street No. 605 S. Bouldin St. (If rural, give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrence Hamann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
61 ?			hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation BUTCHER

11. Industry or business MEAT

FATHER
12. Name UNKNOWN
13. Birthplace

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7-9-47 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL RD.

18 (a) Funeral director Lasky & Zeiler Inc.
(b) Address 403 S. WOLFE STS.

19 (a) (Signature by registrar) (b) Huntington Williams M.D. Registrar

JUL 8 - 1947

VS 150

MEDICAL CERTIFICATION

AM

20. DATE OF DEATH July 6 1947, at 12.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1947 to July 6 1947, and that I last saw h im alive on July 6 1947

Immediate cause of death Myocardial failure — Duration Unknown

Due to

Due to — over

Other Conditions Possible Cerebro-Vascular accident
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: no additions to above dx.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard T. Binford M.D.
Address Balt. City Hosp. Date signed 7-7-47

Certificate subject to the approval of Medical Examiner
Howard J. Simms, M.D.

G53280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. G53280

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument at Rutland ave.
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Brooklyn (If outside city or town limits, write RURAL and give town)
(d) Street No. 4124 Hague ave. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ANTONIE KECK

3 (b) If veteran, name war ----

3 (c) Social Security Account No. ----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 18, 1898

8. AGE: Years	Months	Days	If less than one day
48	10	19	0 hr. min.

9. Birthplace Buttenwiesen, Germany (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name Joseph Young
13. Birthplace Unknown

MOTHER
14. Maiden Name Mathilde Young
15. Birthplace Unknown

16 (a) Informant Mr. Albert L. Nusser
(b) Address 4124 Hague ave. Brooklyn,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/9/47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A.A. Co. Md.

18 (a) Funeral director Chas. J. Evans Son Inc.
(b) Address 118 N. Mt. Royal Ave.

JUL 8 - 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1947, at 1.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 3 1947, to July 7 1947, and that I last saw h[illegible] alive on July 7 1947.

Immediate cause of death	Duration
Carcinoma of ovary with	
Due to Generalized metastases,	
Due to Ascites & pleural effusions.	
Due to Cachexia	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: Carcinoma of ovary, metastases

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Marvin Shapiro M.D.
Address Sinai Hospital Date signed 7/5/47

G53281

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/21

Registered No. G53281

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 CAROLINE
(c) Hospital or institution: ST. JOSEPH'S HOSP. 6-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 2716 Orleans St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME MORRIS, JOHN

3 (b) If veteran, name war —

3 (c) Social Security Account No. 192-14-4184

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 1. 1926

8. AGE: Years	Months	Days	If less than one day
20	7	6	hr. min.

9. Birthplace Sugarnotch Pa. (Town, county, and state)

10. Usual Occupation Bethlehem Steel

11. Industry or business

FATHER 12. Name Benjamin Morris

13. Birthplace Sugar Notch Pa

MOTHER 14. Maiden Name Victoria Gorka

15. Birthplace Manticoke Pa.

16 (a) Informant Mr. B. Morris

(b) Address Sugarnotch Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 10. '47 (month) (day) (year)

(c) Cemetery or crematory Holy Family

Location Sugar Notch Pa

18 (a) Funeral director L. Freemanville Son

(b) Address 6067 Norford Rd

19 (a) JUL 8 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1947 at 6:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from ~~June~~ 6/5 1947, to July 7 1947 and that I last saw h IM alive on July 7 1947.

	Duration
Immediate cause of death PERITONITIS	1 MO.
Due to FECAL FISTULA	1 MO
Due to RUPTURED APPENDIX	1 MO
Other Conditions INANITION	

(Include pregnancy within 3 months of death)

Date of operation 6/5/47, 6/20/47

Major findings of operation: PERITONITIS, INTESTINAL OBSTRUCTION

of autopsy: PERITONITIS

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry P. Porter M. D.
Address St. Joseph's Hosp. Date signed 7/8/47

VS 150

G53282 423033 269

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

Registered No. G53282

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 S. Deane St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth M. Schmidt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	widow

6 (b) Name of husband or wife John Schmidt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-12-70

8. AGE: Years	Months	Days	If less than one day
77	5	23	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business Ot. Home.

FATHER
12. Name John Feuller
13. Birthplace Germany

MOTHER
14. Maiden Name Anna M. Boutzel
15. Birthplace Germany

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-9-47. (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location Herman Mill Rd. Balto. Co. Md.

18 (a) Funeral director Charles S. Zeiler
(b) Address 2695 Fait Ave.

19 (a) (Date rec'd by registrar) (b) Signature for Williamson Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 - 1947 at 11 39 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-27- 1947 to 7-5- 1947, and that I last saw her alive on 7-5- 1947.

Immediate cause of death Bronchopneumonia — Duration 48 hrs
Due to Extensive infection — 1 mo.
Due to Diabetes, severe
Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)
Date of operation 18 June 47
Major findings of operation: Occlusive vascular disease
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature James R. Cantrell, M.D.
Address The Johns Hopkins Hospital 7/8/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G53283

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light St.

(c) Hospital or institution: South Balto. Gen Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hours

(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Anne Arundel

(c) City or town Lakeshore

(If outside city or town limits, write RURAL and give town)

(d) Street No. Pasadena P.O.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Sarah A. Lane

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Theo. W. Lane

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 7, 1883

8. AGE: Years 64 | Months 5 | Days 29 | If less than one day hr. min.

9. Birthplace Rochester N.Y. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Not Known

13. Birthplace "

MOTHER 14. Maiden Name Margaret Stone

15. Birthplace

16 (a) Informant Mrs. Leonard

(b) Address Lakeshore, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/8/47 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Parkville, Md.

18 (a) Funeral director J. Fanning & Son

(b) Address Lafayette Ave & Washington Blvd

19 (a) [redacted] (b) Received for Burial, (Date) (Filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1947, at 7:48 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1947, to July 6 1947, and that I last saw her alive on July 6 1947.

Immediate cause of death: Cardiac failure — Duration: 7 yrs

Due to: Arteriosclerotic Heart Disease

Due to:

Other Conditions: Colostomy for 21 years

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

Signature Harold Dillon

Address South Balto Gen Hosp Date signed July 6. M.D.

VS 150

C53284

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 194a

Registered No. C53284

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4223 Pimlico Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4223 Pimlico Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Israel Krish

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 54 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Merchant

11. Industry or business

FATHER
12. Name Moses
13. Birthplace Russia

MOTHER
14. Maiden Name Jennie
15. Birthplace Russia

16 (a) Informant Ida Krish
(b) Address 4223 Pimlico Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/9/47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Plot 2 Sec. D Hamilton

18 (a) Funeral director Jack Lewis Inc
(b) Address 1409 E Balto St.

19 (a) JUL 8 - 1947 (Date rec'd by registrar) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7, 1947, at 5 P. M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Signed 7-8-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

C53285

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. C53285

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Denison St.
(c) Hospital or institution:
Crawford Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ---------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3407 Mondawmin Ave.
(If rural give location)
(e) Citizen of foreign country? ---------- (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Fenwick Greenwell

3 (b) If veteran, name war ----------
3 (c) Social Security Account No. ----------

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband ##### Robert E. Greenwell
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1877

8. AGE: Years 69 | Months 6 | Days 12 | If less than one day --- hr. --- min.

9. Birthplace St. Mary's County, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business ----------

FATHER
12. Name Sims Fenwick
13. Birthplace Maryland

MOTHER
14. Maiden Name Cora Dunbar
15. Birthplace Maryland

16 (a) Informant Robert E. Greenwell
(b) Address 3109 Brighton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/9/47 (month) (day) (year)
(c) Cemetery ###### New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Myers and Son
(b) Address 805 N. Calvert St.

JUL 8 - 1947 (Date rec'd by registrar)
(b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/5/47 19 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 28 1946, to 7/5/47 19, and that I last saw h. alive on 7/5/47 19.

Immediate cause of death: Cerebral Hemorrhage + paralysis — Duration: about 4 Mo
Due to: advanced arteriosclerosis — about 10 yrs
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter Dunbar M. D.
Address 220 Harrison Blvd
Date signed July 8/47

G53286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G53286 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital 15-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 hours
(e) Length of stay in Baltimore (yrs., mos., or days) 53 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (if outside city or town limits, write RURAL and give town)
(d) Street No. 2755 Baker St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Claud Williams

3 (b) If veteran, name war: WW I
3 (c) Social Security Account No.: unknown

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Rose C. Hoffman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 17, 1894

8. AGE: Years	Months	Days	If less than one day
53	5	20	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Printer
11. Industry or business

FATHER
12. Name George Williams
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name ?
15. Birthplace Balto., Md.

16 (a) Informant Records
(b) Address U. S. Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/9/47 (month) (day) (year)
(c) Cemetery or crematory ####### Baltimore National
Location Baltimore, Md.

18 (a) Funeral director H. W. Meare and Son
(b) Address 805 N. Calvert St.

19 (a) JUL 8 - 1947 (Date rec'd by registrar) (b) Huntington Nekimmons, M.D. Address

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1947, at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 6, 1947, to July 7 1947, and that I last saw him alive on July 7 1947.

Immediate cause of death
1. Hypertensive cardiovascular disease — Duration
2. Congestive heart failure.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 7/7/47

VS 150

X

G53287

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓1707

Registered No. G53287

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1520 Sheffield Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Langston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-31-32

8. AGE: Years 14 | Months 11 | Days 6 | If less than one day hr. min.

9. Birthplace Va. (Alexandria) (Town, county, and state)

10. Usual Occupation School

11. Industry or business

FATHER 12. Name Roger B. Langston

13. Birthplace Boston Mass

MOTHER 14. Maiden Name Anna Emily Crowe

15. Birthplace Newport News Va.

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-9-47 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill
Location ~~9 a. C. M. Easton, Inc. Edmondson~~

18 (a) Funeral director Williams Cook Inc.

(b) Address 1217 St. Paul St.

19 (a) 8-1947 (Date received by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1947, at 10 20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1947 to July 7 1947 and that I last saw him alive on July 7 1947.

Immediate cause of death	Duration
Peritonitis and Bilateral Hemothorax	3d.
Due to	
Due to Accident	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 7-6-47

Major findings of operation: 1) Rupture spleen 2) Perforation greater curvature of stomach 3) Rupture of pancreas

of autopsy: 4) Bilateral hemothorax

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident 27/9
(b) Date of occurrence 7/6/47 at 8 45 P.M.
(c) Where did injury occur? 1501 Hanover Balto. Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public While at work? No (Specify type of place)
(e) Means of injury Riding motor bike - struck tree
23. Signature A. B. Morrow
Address A. H. H. Date signed 7-7-47 M.D.

Howard J. Haggerty, M.D.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C53288

CWK-111080

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1477

Registered No. C53288

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Month
(e) Length of stay in Baltimore (yrs., mos., or days) Remain Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1408 N. Bethel Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Dolores Lipscomb

S 81358

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Worthington

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 4-1928

8. AGE: Years 18 | Months 8 | Days – | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward Thomas
13. Birthplace Maryland

MOTHER
14. Maiden Name Sadie Henry
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 9-47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Baltimore, Md

18 (a) Funeral director Mrs Ida Bailey
(b) Address 1421 E Jefferson st

19 (Signature and title of local registrar) July 8 - 1947 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 19 47, at 2:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 19 47, to July 4 19 47, and that I last saw h 9r alive on July 4 19 47.

	Duration
Immediate cause of death Bilateral pulmonary embolism and infarction	
Due to Iliac and Inferior vena cava thrombosis	
Due to Post partum parametritis	
Other Conditions Pulmonary atelectasis, bilateral. (Include pregnancy within 3 months of death)	over

Date of operation 7/4/47
Major findings of operation: Ligation inferior vena cava
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature W. H. Gibbs
Address Baltimore, Md. Date signed 7/5/47

X

G53289

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G53289 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3448 Reisterstown Road

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3448 Reisterstown Road (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Barnett Weinstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Late Annette

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years 81 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER

12. Name Unknown

13. Birthplace Russia

MOTHER

14. Maiden Name Unknown

15. Birthplace Russia

16 (a) Informant Abe Weinstein

(b) Address 4307 Forrest Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 9, 1947 (month) (day) (year)

(c) Cemetery or crematory Hebrew Mt Carmel Cem

Location German Hill Road

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1124-1126 W North Ave

19 JUL 8 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION 8.45

20. DATE OF DEATH July 8 1947, at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1945 19... to Sept 19...; and that I last saw h alive on 7/8/47 19...

Immediate cause of death: acute coronary thrombosis — Duration: Sudden

Due to: arteriosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Theodore Kurtz M. D.

Address 2904 Reisterstown Rd Date signed 7/8/47

X

G53290

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

Birth Cert.-Y-82869 **CERTIFICATE OF DEATH** 161c

Registered No. G53290

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
The Johns Hopkins Hospital 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 1/2hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 6 1/2 Hours

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2033 E. Baltimore Street
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Bozo

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 4, 1947

8. AGE: Years | Months | Days | If less than one day: 6 hr. 30 min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business.....

FATHER
12. Name Michael Bozo
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Helen Lechmanik
15. Birthplace New Jersey

16 (a) informant Hospital Records
(b) Address Johns Hopkins Hospital

17 (a)..... (b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location.....

18 (a) Funeral director.....
(b) Address.....

19 (a) Date rec'd by Registrar (b) .....

Johns Hopkins Medical Schoo JUL 8 1947
Commissioner of Health
JUL 8 - 1947
Huntington Williams, M.D.

VS 150*

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1947, at 4:30PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 4 1947, to July 4 1947, and that I last saw h or alive on July 4 1947.

Immediate cause of death..... | Duration

Due to Maternal diabetes.

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature BC Williams M.D.
M. D.
Address Johns Hopkins Hospital Date signed 7-7-47

X

G53291 Birth Certificate 4-82873

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

G53291
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Talbot Co.
(c) City or town Longwoods
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Emma Griffin
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race Black
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 7-3-47
8. AGE: Years | Months | Days | If less than one day hr. — min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name Albert Griffin
13. Birthplace Md.
MOTHER 14. Maiden Name Emma Bowser
15. Birthplace Md.
16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JUL 8 1947
18 (a) Funeral director Commissioner of Health
(b) Address
19 (a) 7-8-1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-4 1947, at 4:10 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 7-3-1947 to 7-4-1947
and that I last saw her alive on 7-4-1947

Immediate cause of death	Duration
RESPIRATORY FAILURE WITH CYANOSIS	
Due to ASPHYXIA NEONATORUM AND PREMATURITY	
Other Conditions MOTHER - SEVERE TOXEMIA	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature William A. Spencer M.D.
Address JOHNS HOPKINS HOSPITAL - HARRIET LANE HOME Date signed 7/8/47

VS 150

G53292 BC#B-82440 (1)

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

160a

Registered No. G53292

MARGIN RESERVED FOR BINDING. The information should be carefully supplied. Every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 938 W. Fayette Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wooden

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29, 1947

8. AGE: Years	Months	Days	If less than one day
		5	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Leroy Wooden
13. Birthplace

MOTHER
14. Maiden Name Mamie Thompson
15. Birthplace South Carolina

16 (a) Informant Hospital Records
(b) Address Johns Hopkins Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JUL 8 1947

18 (a) Funeral director
(b) Address, Commissioner of Health

19 JUL 8 - 1947 (b) Washington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1947, at 2:45A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 29 1947 to July 4 1947, and that I last saw her alive on July 4 1947.

Immediate cause of death	Duration
intracranial hemorrhage	
Due to fetal distress in utero.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature BC Williams M. D.
Address Johns Hopkins Hospital Date signed 7-7-47

G53293

BC# 385562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G53293 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 836 W. Pratt St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-1-47

8. AGE: Years — | Months — | Days — | If less than one day: 2 hr. — min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Frank Williams
P
13. Birthplace

MOTHER 14. Maiden Name ?
15. Birthplace ?

16 (a) Informant:
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JUL 8 1947

18 (a) Funeral director
(b) Address Commissioner of Health

19 JUL 8 - 1947 Wm Livingston Williams M.D. Registrar
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-2-1947 at 5:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-1-47 to 7-2-1947.
and that I last saw him alive on 7-2 1947

Immediate cause of death: Bronchial pneumonia — Duration 4 hrs.
Due to Prematurity
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J M Edmunds M. D.
Address Baltimore Md. Date signed 7-2-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53294

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

Registered No. G53294

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Lombard
(c) Hospital or institution:
University Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 621 George St.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Banks

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [illegible]

8. AGE: Years 71 | Months | Days | If less than one day hr. min.

9. Birthplace Wash. D.C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name albert Banks
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Same
(b) Address

17 (a) Burial (b) Date thereof July 8, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Brooklyn, Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1009 Brantley Ave.

19 JUL 8 - 1947 (date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-3 1947, at 10:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-3 1947, to 7-3 1947, and that I last saw him alive on 7-3 1947.

Immediate cause of death Circulatory collapse — Duration

Due to Hematemesis

Due to Esophageal Varices & Cirrhosis of Liver

Other Conditions Arteriosclerotic C-V Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Burchenal, M.D.
Address Univ. Hosp. Date signed 7-8-47

X

G53298 Last Certificate No. 8288f

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 160a

Registered No. G53295

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division Street
(c) Hospital or institution: Provident Hospital 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 103 Cambrai Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Rosalee Hines

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/3/47

8. AGE: Years 0 | Months 0 | Days 0 | If less than one day: 15 hr. 15 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Newborn Infant

11. Industry or business

FATHER
12. Name Charles H. Hines
13. Birthplace Brooklyn, Maryland

MOTHER
14. Maiden Name Rose Watkins
15. Birthplace Baltimore, Maryland

16 (a) Informant Charles H. Hines
(b) Address Brooklyn Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 8, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location Brooklyn Md

18 (a) Funeral director Thos O. Wilson
(b) Address 1010 Brantley Ave

19 JUL 8 - 1947 (Date filed by Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/3/47 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/3 1947 to 7/3 1947, and that I last saw her alive on 7/3 1947.

Immediate cause of death: Cerebral Concussion — Duration

Due to: Prolonged Second Stage of Labor

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature I. B. Higgins / M. Moore M.D.
Address 2343 Madison Ave Baltimore Date signed 7/9/47

X

G53296

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G53296 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard St. & Lanvale Ave.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Cecil
(c) City or town Perryville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William E. Calvert
3 (b) If veteran, name war ✓
3 (c) Social Security Account No.
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Anna K. Calvert
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 21, 1884
8. AGE: Years 62 Months 7 Days 17 If less than one day hr. min.
9. Birthplace Maryland (Town, county, and State)
10. Usual Occupation Retired R.R.
11. Industry or business

FATHER
12. Name William T. Calvert
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary E. Ann Boyd
15. Birthplace Maryland

16 (a) Informant Anna K. Calvert
(b) Address Perryville Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-11-1947 (month) (day) (year)
(c) Cemetery or crematory Grace Cem. Location Aberdeen, Md.

18 (a) Funeral director Lee A. Patterson & Son
(b) Address Perryville, Md.

19 (a) JUL 8 - 1947 (Date rec'd by registrar) (b) Harford Co. Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-8 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-24 1947 to 7-8 1947, and that I last saw him alive on 7-8 1947.

Immediate cause of death Pulmonary Edema due to cardiac failure, secondary to Genitalia ulcer - post-operative

Due to vaginal and perineal gangrenous ulcerations

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 6-28-47
Major findings of operation: Gangrenous ulcers, penetrating
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carlton Benefield M. D.
Address Md. Date signed 7-8-47

VS 150

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53297

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83a

G53297
Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Blackstone Apt.
(c) Hospital or institution: Charles & 33rd. Street
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. The Blockstone, Charles & 33rd Sts
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha A. Smith

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F.
5. Color or race W.
6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Dr. T.W. Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 77

8. AGE: Years About 70 | Months 3 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Simon P. Schott
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name E A. Schott
15. Birthplace Maryland.

16 (a) Informant Mrs. Louise S. Cockey
(b) Address Blackstone Apt.

17 (a) Burial (b) Date thereof 7/10/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Baltimore Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul Street

19 (a) JUL 9 1947 (b) [illegible]
(Date received by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 July 1947, at 4a M

21. I certify that death occurred on the date above stated; that I attended deceased from 1942 to 8 July 1947.
and that I last saw her alive on 7 July 1947:

	Duration
Immediate cause of death: Cerebral Hemorrhage	9 days
Due to: Cerebral Arterio-Sclerosis	
Chronic Art. Hypertension	1942
Due to: Nephritis	
Other Conditions: Enlarged Heart.	1942

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Carroll Lockard M. D.
Address 2925 N. Charles St Date signed 9 July 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53298

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G53298

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1604 Chesapeake ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1604 Chesapeake ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sallie Ann Tallie

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	married

6 (b) Name of husband or wife Charles Tillie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace macon N. C.
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Samuel Allgood
13. Birthplace N. C.

MOTHER
14. Maiden Name Unknown
15. Birthplace N C.

16 (a) Informant James Tallie
(b) Address 1604 Chesapeake

17 (a) Burn (Burial, cremation, or removal) (b) Date thereof July 9 47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director James A Hayes
(b) Address 1142 W Lexington

19 (a) Filed JUL 9 1947 (b) Registrar Thurlington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 1947, at 3'16 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-28 1946 to 7-5 1947 and that I last saw her alive on 7-5-47 1947

Immediate cause of death	Duration
Carcinomatosis	7 d
Cardiac & Respiratory Failure	7 months
Due to Carcinoma of Cervix	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis S. Watson M. D.
Address 346 Madison Ave Date signed 7 8 47

G53299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G53299 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1911 Bank St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1911 Bank St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Peter John Czerwinski

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Veronica

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1868

8. AGE: Years	Months	Days	If less than one day
79	9		hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Bricklayer

11. Industry or business

FATHER
12. Name John Czerwinski
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace Poland

16 (a) Informant Mrs Laura May
(b) Address 1911 Bank St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 10 1947 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore

18 (a) Funeral director Fred W. Ozarowski
(b) Address 1930 Eastern Ave

19 (a) Date received 7-9-1947 Registrar Washington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1947 at 7:20 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 8 1947 to July 7 1947, and that I last saw him alive on July 7 1947.

Immediate cause of death	Duration
Acute Cardiac Dilatation	1 day
Due to Chronic Myocarditis	3 yrs.
Due to Hypertension	4 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John V. Czerwinski
Address 1902 Eastern Ave Date signed 7-8-47 M. D.

VS 150

G53300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

G53300
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution:
Church Home & Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore 21. Ernest
(If outside city or town limits, write RURAL and give town)
(d) Street No. Box 367 Route 13.
(If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Pius Mamas.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Constance Mamas
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) July 11 1872.

8. AGE: Years	Months	Days	If less than one day
74	11	27	hr. min.

9. Birthplace Lithuania
(Town, county, and state)
10. Usual Occupation Tanner.
11. Industry or business Tanner.

FATHER
12. Name Frank Mamas.
13. Birthplace Lithuania

MOTHER
14. Maiden Name Agnes.
15. Birthplace Lithuania.

16 (a) Informant Sophie (Mrs Tanner.
(b) Address Box 367 Route 13

17 (a) Burial (b) Date thereof July 11-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Rd

18 (a) Funeral director Joseph Kasmarska
(b) Address 608 Washington Blvd

19 (a) (b)
(Date received by registrar)

JUL 9 1947

Huntington Williams M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1947, at 12 42 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1, 1947, to July 8 1947 and that I last saw him alive on July 3, 1947

Immediate cause of death	Duration
Cardiac insufficiency.	2 yrs.
Due to Arteriosclerosis heart disease	20 yrs.
Due to	
Other Conditions Arteriosclerosis general. Cardiac enlargement.	20 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Bachrach M. D.
Address Church Home & Hosp. Date signed 7/8/47

G53301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V/124B

Registered No. G53301

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1626 Madison Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1626 Madison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Rosetta Bruce

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W.

6 (b) Name of husband or wife Willis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 5-1870

8. AGE: Years	Months	Days	If less than one day
77	6	2	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace " " "

MOTHER
14. Maiden Name Unknown
15. Birthplace " " "

16 (a) Informant Alice Bruce
(b) Address 1626 Madison Ave

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 7-10-47 (month) (day) (year)
(c) Cemetery or crematory Western Star
Location Balto. Co

18 (a) Funeral director Samuel W. Sullivan Jr.
(b) Address 1011 N. Arlington Ave

(c) Date received by registrar JUL 9 - 1947 Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1947, at 11 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1 1947 to 7/7 1947 and that I last saw her alive on 7/7 1947

Immediate cause of death: Myocarditis
Due to Cirrhosis of Liver
Due to Sclerosis (Arteriosclerosis)
Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: 2nd. 2nd. 2nd.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jas. A. Blake
Address 1327 N. Central Ave Date signed 7/8/47 M. D.

G53302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G53302

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 713½ W. Saratoga St

(c) Hospital or institution: 4

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 15yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 713½ W. Saratoga St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME LACE HORNE (Lester Hall)

3 (b) If veteran, name war: No

3 (c) Social Security Account No.:

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife:

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/19/1901

8. AGE: Years 46 | Months 4 | Days 15 | If less than one day hr. min.

9. Birthplace Matthews, N.C. (Town, county, and state)

10. Usual Occupation Chemical Worker

11. Industry or business

FATHER

12. Name Gus Horne

13. Birthplace N.C.

MOTHER

14. Maiden Name Jennie

15. Birthplace N.C.

16 (a) Informant Mrs. Mary G. Neely (Daug)

(b) Address 1912 Edwin St. Charlotte, N.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/9/47 (month) (day) (year)

(c) Cemetery or crematory Balto. National

Location Baltimore, Md.

18 (a) Funeral director Charles G. Cooper

(b) Address 510-12 N. Carrollton Ave

JUL 9 - 1947 (a) (Date rec'd by Registrar) (b) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/4/47 19 , at 9:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jun 2 19 47 to July 4 19 47 and that I last saw h[illegible] alive on July 4 19 47

Immediate cause of death	Duration
Cardiac Failure	years
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [signature]

Address [illegible] Date signed July 9 1947

X

C53303

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. C53303

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 404 McMechen St
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 404 McMechen St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY C BROWN

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband Ronnie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/25/1887

8. AGE: Years	Months	Days	If less than one day
60	0	10	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Concrete Finisher
11. Industry or business

FATHER
12. Name Thomas Brown
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Carolyn, Wilson
15. Birthplace Baltimore, Md.

16 (a) Informant Ronnie Brown(W)
(b) Address 404 McMechen St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/12/47 (month) (day) (year)
(c) Cemetery or crematory Laurel
Location Baltimore, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N.Carrollton Ave

19 (a) JUL 9 1947 (Date received by Registrar) (b) Burrington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/7/47 19 , at 9:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1947 to July 7 1947 and that I last saw h[illegible] alive on July 6 1947.

Immediate cause of death Cardio-Renal Vascular Disease — Duration ?
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ben Harris M. D.
Address 1202 N Carlton Date signed 7/9/47

G53304

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G53304
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 819 N. Eagley Av
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 819 N. Eagley Av (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Weaver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Charles F. Weaver
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug 13 1873

8. AGE: Years	Months	Days	If less than one day
74 73	10	24	hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Hd Home
11. Industry or business

FATHER
12. Name John Law
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine Hemsley
15. Birthplace Md.

16 (a) Informant Harry M. Weaver
(b) Address 809 N. Eagley Av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-10-47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave

18 (a) Funeral director Wm. C. Miller Inc.
(b) Address 2435 E. Oliver St

19 (a) JUL 9 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July - 7 - 1947, at 11 PM M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1946, to July 7 1947, and that I last saw her alive on July 7 1947:

Immediate cause of death	Duration
Acute Cardiac Failure.	
Due to Cardiac Decompensation	
Due to Arteriosclerosis.	
Other Conditions Diabetes	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward A. Flanigan M.D.
Address 3503 Fait ave Date signed 7-8-47

921

G53305 Girl Catterlin D-83149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

Registered No. G53305

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address .....

(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (~~yrs., mos., or days~~) 2 hrs 42

(e) Length of stay in Baltimore (yrs., mos., or days) " "

2. USUAL RESIDENCE OF DECEASED:

(a) State MARYLAND (b) County .....

(c) City or town BALTIMORE 5

(If outside city or town limits, write RURAL and give town)

(d) Street No. 613 N. Highland Ave

(If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME BABY GIRL FRANZ

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-7-47 (1 hr 33 min)

8. AGE: Years	Months	Days	If less than one day
			2 hr. 42 min.

9. Birthplace BALTIMORE, MD.

(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER

12. Name JOHN EDWARD WILLIAM FRANZ

13. Birthplace MARYLAND

MOTHER

14. Maiden Name WILMA MARTHA KERNER

15. Birthplace MARYLAND

16 (a) Informant Mr John Edward William Franz

(b) Address 613 N. Highland Ave, Balto 5

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-9-47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Frederick Ave

18 (a) Funeral director John C. Miller Inc

(b) Address 2435 E. Oliver St

19 (a) Date received JUL 9 1947 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-7 1947, at 4:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-7 1947 to 7-7 1947 and that I last saw h e r alive on 7-7 1947.

Immediate cause of death Basilar hemorrhage — Duration 2+ hrs

Due to Breech extraction complicated by Superficial to effleurement of heart

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....

(e) Means of injury .....

23. Signature E B Chamberlin M. D.

Address Union Memorial Hosp Date signed 7-1-47

Baltimore 18 Md X

G53306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G53306
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Port Covington-Quarantine
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Banaco Island Republic of Honduras
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Edgar A. WooDS

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
37			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/9/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Old Annapolis Rd
18 (a) Funeral director Chas R. Law
(b) Address 502 Madison Ave

19 JUL 9 - 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3, 1947, at 3 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary arteriosclerosis
Myocardial degeneration
~~Acute~~ Edema of Lungs
Acute passive congestion of liver, spleen
~~Other Conditions~~ and Kidneys.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George E. Merrill M.D.
Medical Examiner.
Date signed 7/7/47

G53307

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G53307

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1214 N. Wolfe St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1214 N. Wolfe St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rodgers Lightfoot

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5 1902

8. AGE: Years	Months	Days	If less than one day
45	3	21	hr. min.

9. Birthplace Creeve Va. (Town, county, and state)
10. Usual Occupation Unemployed Laborer
11. Industry or business

FATHER
12. Name Pascha Lee Lightfoot
13. Birthplace Creeve Va

MOTHER
14. Maiden Name Annie Bell Fitzgerald
15. Birthplace Creeve Va.

16 (a) Informant Carrie Williams
(b) Address 1214 N. Wolfe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 9/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A. A. County Md

18 (a) Funeral director Mrs. Lott & Ellwood - Dyt
(b) Address 1129 N. Caroline St.

JUL 9 - 1947

(a) (b) Date received by registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 July 1947 at 9:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-10 1947 to 7-5 1947 and that I last saw h[illegible] alive on 7-4 1947.

Immediate cause of death	Duration
Bronchopneumonia	25 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stanford P. Innerarity M. D.
Address 2709 Druid Hill Date signed 7-8-47

G53308 BARBARA

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 93c

Registered No. G53308

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Type correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Ln
(c) Hospital or institution:
Home for the Aged Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Lenz (Lunz)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	W.

6 (b) Name of husband or wife Andrew Lenz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1845

8. AGE: Years	Months	Days	If less than one day
102	4 3	-	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Henry Kondlick
13. Birthplace

MOTHER 14. Maiden Name Mary —
15. Birthplace

16 (a) Informant Sister Superior The Home
(b) Address 1200 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 11, 1947 (month) (day) (year)
(c) Cemetery or crematory Parkton
Location Baltimore

18 (a) Funeral director Wm. Wiedefeld
(b) Address 900 East Biddle St.

19 (a) JUL 9 1947 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1947, at 10:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1947, to July 8 1947, and that I last saw him alive on July 6 1947.

Immediate cause of death Myocarditis — Duration 2 yrs.
Due to
Due to
Other Conditions Chronic Arteritis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Carol Fraher M. D.
Address 1520 N. Broadway Date signed 7/9/47

G53309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No. G53309

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1619 Sulgrave Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1619 Sulgrave Ave (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Leah Kearns.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Samuel P. Kearns
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1, 1885

8. AGE: Years	Months	Days	If less than one day
61	11	6	hr. min.

9. Birthplace Baltimore City (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business at home

FATHER 12. Name George Sokewinn
13. Birthplace Germany

MOTHER 14. Maiden Name Helena Frank
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Samuel P. Kearns
(b) Address 1619 Sulgrave Ave

17 (a) buried (b) Date thereof 7/10/47 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Ridge
Location Pikesville, Md.

18 (a) Funeral director Co. Vernon Lemmon
(b) Address 4609 Park Heights

19 (a) Hamilton-Williams Mfg. Co.
(Date rec'd by registrar) JUL 9 - 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1947, at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1946 to July 7 1947, and that I last saw her alive on July 7 1947.

Immediate cause of death	Duration
Pulmonary Edema	6 hrs
Due to Congestive Heart Failure	
Due to Mitral + Aortic Stenosis	2 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herman R. Wantz
Address Date signed 7/9/47 M. D.

C53310

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C53310

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 729 McCabe Ave.,
(c) Hospital or institution:
Son's Home
(d) Length of stay in [redacted] (yrs., mos., or days) 1 dy.
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5001 Litchfield Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph DiPeitro,

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widower

6 (b) Name of husband or wife Clorinda DiPeitro
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1888

8. AGE: Years	Months	Days	If less than one day
59	0	11	hr. min.

9. Birthplace Italy,
(Town, county, and state)
10. Usual Occupation Presser,
11. Industry or business Clothing,

FATHER
12. Name Antonio DePeitro,
13. Birthplace Italy,

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Italy,

16 (a) Informant Mrs. Amelia Campitelli,
(b) Address 5100 Arbuts Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 7/12/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer,
Location Baltimore City,

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

19 (a) JUL 9 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7, 1947 19 at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/6 1947 to 7/7 1947, and that I last saw him alive on 7/7 1947.

Immediate cause of death	Duration
Coronary Thrombosis	24 hrs
Due to Diabetes Mellitus	5 yrs
Due to	
Other Conditions Arteriosclerosis	5 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 1901 Eutaw Place Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cost age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G53311

BALTIMORE CITY HEALTH DEPARTMENT ✓ G53311

CERTIFICATE OF DEATH 122a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3706 Woodhaven
(if rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Isaac ~~Gurson~~ Gurson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, (widowed), or divorced.

6 (b) Name of husband or wife Dora

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 77 | Months | Days | If less than one day hr. min.

9. Birthplace Lithuania
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name unknown
13. Birthplace Russia

MOTHER 14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Bernard Lunsky
(b) Address 3706 Woodhaven Ave

17 (a) Burial (b) Date thereof 7-10-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Cumberland Md

18 (a) Funeral director Jack Lewis Inc

(b) Address 409 E Balto St

19 (a) JUL 9 1947 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1947, at 0¹² M

21. I certify that death occurred on the date above stated; that I attended deceased from 8 July 1947, to 8 July 1947, and that I last saw h[illegible] alive on 8 July 1947.

Immediate cause of death Cardiac Vascular Accident — Duration

Due to Hypertension

Due to

Other Conditions Hyperinal Psychosis Gall Bladder Trouble
(Include pregnancy within 3 months of death)

Date of operation 8 July 1947

Major findings of operation: Inoperable disease

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lloyd T McCormick M. D.

Address W. B & H. Date signed 7-9-47

G53312 G53312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2625 Violet Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 41yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2625 Violet ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barnett B. Wolf

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1884

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name Eliezer
13. Birthplace Lith

MOTHER 14. Maiden Name Esther
15. Birthplace Lith

16 (a) Informant Ida Wolf
(b) Address 2625 Violett ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-9-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phila Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1859 E Baltimore St

19 (a) (b)
(Date received by registrar) (Registrar)

9 1947 Huntington Williams

150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-8-1947 at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 3, 1947 to July 8, 1947. and that I last saw him alive on July 8, 1947.

Immediate cause of death	Duration
Coronary Insufficiency	
Myocardial failure	
Due to Arteriosclerosis —	5 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathan B. Lynch M.D.

Address 1810 Eutaw Pl. Date signed M 7 D 9 47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT ✓ G53313

G53313 **CERTIFICATE OF DEATH** 94a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 E Fayette St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 d
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1913 E Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Henry M. Stone

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widow

6 (b) Name of husband or wife Hannah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1861

8. AGE: Years	Months	Days	If less than one day
86			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER — 12. Name William
13. Birthplace Russia

MOTHER — 14. Maiden Name Brown
15. Birthplace Russia

16 (a) Informant William Stone
(b) Address 2230 Garrison Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-9-47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt. Carmel
Location

18 (a) Funeral director Jack Levin Inc
(b) Address 1429 E. Balto. St.

19 (a) 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 — 9 — 1947 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/3 1947 to 7/8 1947 and that I last saw he alive on 7/8/47 1947

Immediate cause of death Cardiac dela[illegible] — Duration

Due to Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature M Goldeckel M. D.
Address 2220 Linden Ave Date signed 7/9/47

150

G53314

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G53314 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2254 Brookfield Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 1 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2254 Brookfield Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nils Bloomberg

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sophie Bloomberg
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1885

8. AGE: Years 62 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Sweden (Town, county and state)

10. Usual Occupation Tailor (Self)

11. Industry or business —

FATHER
12. Name —
13. Birthplace Sweden

MOTHER
14. Maiden Name —
15. Birthplace Sweden

16 (a) Informant Herman Bloomberg
(b) Address 1621 Linton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-11-47 (month) (day) (year)
(c) Cemetery or crematory Workmen Circle
Location Hebrew Mt. Carmel

18 (a) Funeral director Jacob Levine Inc
(b) Address 1439 E. Baltimore St

9 se 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-9-47 19 ... at 9.30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 31, 1947 to July 9, 1947. and that I last saw him alive on July 9, 1947.

Immediate cause of death: Coronary Thrombosis
Myocardial failure — Duration: 1 day.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: was operated upon at Sinai Hospital for Prostatectomy April 1947

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathan H. Shapiro, M.D.
M. D.
Address 1810 Eutaw Pl. Date signed 9/9/47

G58315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G53315 Registered No.

Balto. Md 83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Provident Hospital
(b) Street address 1514 Dennison St
(c) Hospital or institution Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 53

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
Street No. 1214 Madison Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Lasby Smith

3 (b) If veteran, name war WORLD WAR I
3 (c) Social Security Account No. 211-07-3762

4. Sex M | 5. Color or race N | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Ida Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/24/1893

8. AGE: Years 53 | Months 7 6 | Days 9 14 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Elevator operator
11. Industry or business

FATHER
12. Name John Smith
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Maimie Talbott
15. Birthplace Baltimore Md

16 (a) Informant Sister Blanche Day
(b) Address 1446 McCulloh St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 11, 1947 (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew Cem
Location Baltimore, Md.

18 (a) Funeral director Geo. J. A. Lipsett Jr.
(b) Address 1631 Madison Ave

JUL 9 - 1947 (b)
(Date rec'd by registrar) Registrar

Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/7/47 1947, at 9:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 3 1947 to July 7 1947 and that I last saw h[illegible] alive on July 7 1947

Immediate cause of death Subarach Noid Hemorrhage

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 5 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stafford P. Summerlin M. D.
Address 1309 Linden Ave. Date signed 7-8-47

X

G53316

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓G53316 Registered No. 95c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital. D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 822 Tyson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY McGOWAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Robert McGowan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1891

8. AGE: Years 55 | Months 7 | Days 10 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name John Miller
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Helen Dent
15. Birthplace Howard Co. Md.

16 (a) Informant Robert McGowan
(b) Address 822 Tyson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-10, 1947 (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location Balto Md.

18 (a) Funeral director Mrs. K. R. Williams
(b) Address 322 N. Schroeder St.

19 (a) 7-9-1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7, 1947, at 2 p.m.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion
Secondary arteriosclerosis
~~Due to~~ Hypertrophy & Dilatation of Heart

Other Conditions Acute Pulmonary Edema
Edema of Brain
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mendelsohn M.D. Medical Examiner.
Date signed 7-8-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53317

BALTIMORE CITY HEALTH DEPARTMENT ✓ G53317 Registered No.

CERTIFICATE OF DEATH 93c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Road
(c) Hospital or institution:
Harford Road Convalscent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore ✓
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4700 Harford Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH CARROLL HORNER

3 (b) If veteran, name war ----

3 (c) Social Security Account No. ----

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife ? Horner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 79 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Catherine Carroll
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Clara O'Donnell
(b) Address 407 East 22nd Street

17 (a) Burial (Burial, cremation, or removal). (b) Date thereof 7/9/47 (month) (day) (year)
(c) Cemetery or crematory METHODIST CEM.
Location FINKSBURG. MD

18 (a) Funeral director WIEDEFELD AND SON
(b) Address GREENMOUNT AVE & 22ND

JUL 9 - 1947 (Date received by Registrar) (b) Registrar

VS 150

Huntington Hitchcock, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7th 1947, at 7:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 17 1947 to July 7 1947, and that I last saw her alive on June 30 1947.

	Duration
Immediate cause of death a. Chronic Arthritis	2 yrs
Due to Myocarditis	yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles P Cawley M. D.
Address 3013 St Paul St Date signed 7-9-47

per Dr E W Fleet
X 1928 Penna Ave

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53318

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G53318
Registered No.

CM. 106485

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE.
(c) Hospital or institution:
Balto . City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Months
(e) Length of stay in Baltimore (yrs., mos., or days) 37 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5408 Denmore AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Young , Louis Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or wife Sarah (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14 - 1880

8. AGE: Years	Months	Days	If less than one day
66	7	23	hr. min.

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Allen
13. Birthplace MD.

MOTHER
14. Maiden Name Harriet Nicholas
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern AVE.

17 (a) Burial (b) Date thereof July 11- 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rock Cem.
Location Cambridge Md

18 (a) Funeral director Elroy F. W. Dean
(b) Address 1100 Bentley ave

19 (a) (Date rec'd by registrar) JUL 9 -v 1947 (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July -7- 1947, at about 8.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 29- 1946 to July -7- 1947 and that I last saw him alive on July 7- 1947

Immediate cause of death
Terminal Bronchopneumonia — Duration 2 days
Due to Pulmonary Congestion
Due to Arteriosclerotic Heart Disease - Failure
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. R. Neuhardt M. D.
Address Balto City Hosp. Date signed 7-8-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The coroner's age is especially important. Physicians: please write the causes of death clearly and legibly.

G53319

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G53319
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2236 E North
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2236 E North
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George S Heim

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Margaret Heim
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 5 1865

8. AGE: Years	Months	Days	If less than one day
82 83	6	2	hr. min.

9. Birthplace Germany
(Town, county and state)
10. Usual Occupation Baker retired
11. Industry or business

FATHER
12. Name Conrad Heim
13. Birthplace Germany

MOTHER
14. Maiden Name Dora Krum
15. Birthplace

16 (a) Informant Margaret Heim
(b) Address 2236 E North Ave

17 (a) Burial (b) Date thereof July 10/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto

18 (a) Funeral director Elliott Funeral Home
(b) Address 2005 Orleans St

JUL 9 1947
(Date received by registrar)

Huntington Williams, M.D.
(Signature of registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1947, at 10:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 17 1946 to July 1947; and that I last saw [illegible] alive on July 1947.

Immediate cause of death Coronary Thrombosis
Due to Ch. Myocarditis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration 7/7/47 8-146

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Krauer M. D.
Address 504 N Rose St Date signed July 9/47

G53320 BALTIMORE CITY HEALTH DEPARTMENT ✓ G53320
Registered No.

CERTIFICATE OF DEATH 94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 118 S Bouldin St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7d
(e) Length of stay in Baltimore (yrs., mos., or days) 21yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 118 S Bouldin (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wiegand Henkel

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Anna Henkel
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) June 2 1886

8. AGE: Years	Months	Days	If less than one day
61	1	6	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name John Henkel
13. Birthplace Germany

MOTHER
14. Maiden Name Gertrude Staffel
15. Birthplace Germany

16 (a) Informant Anna Henkel
(b) Address 118 S Bouldin

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jul 11 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 1947 (a) (b) Date rec'd by [illegible] Registrar

V S 150

MEDICAL CERTIFICATION

45

20. DATE OF DEATH July 8 1947, at 2 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/12 1942 to 7/8/47 19, and that I last saw him alive on 6-15-47 19

Immediate cause of death	Duration
Embolism	
Due to Coronary Sclerosis	6 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Hergmann, M. D.
Address 1710 E 33rd St Date signed 7/8/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G53321 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1815 N Bond St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1815 N Bond St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Siegelen

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 20 1861

8. AGE: Years	Months	Days	If less than one day
86	3	14	19 hr. min.

9. Birthplace Ohio (Town, county, and state)
10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Rev. C. G. W. Siegelen
13. Birthplace Germany

MOTHER
14. Maiden Name Maria Lippd
15. Birthplace Germany

16 (a) Informant Mrs. Marie L. Schultz
(b) Address 1815 N Bond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jul 12 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 210 E Orleans St

19 (a) 1947 (To be filled by registrar) (Signature of Registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1947, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947 to July 8 1947, and that I last saw h alive on July 8 1947.

Immediate cause of death	Duration
Bronchopneumonia	3 d.
Marasmus	1 d
Due to Arteriosclerosis	7 d
Hypertension	7 d
Due to Old cerebral hemorrhage	7 d
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F F A Stearns M. D.
Address 2818 Harford Av Date signed 7-9-47

G53322 BALTIMORE CITY HEALTH DEPARTMENT X ✓ G53322 Registered No.

CERTIFICATE OF DEATH 45c

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 186 days
(e) Length of stay in Baltimore (yrs., mos., or days): 186 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Pa. (b) County:
(c) City or town: New Oxford
(If outside city or town limits, write RURAL and give town)
(d) Street No.: -- (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: Clarence Jacob Schriver

3 (b) If veteran, name war: -
3 (c) Social Security Account No.: 104-14-9284

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary Myers Schriver
6 (c) If alive, give age: ? years
7. Birth date of deceased (mo., day, yr.): Nov. 22, 1891
8. AGE: Years: 55 | Months: 7 | Days: 16 | If less than one day: hr. min.
9. Birthplace: Adams Co. Pa. (Town, county, and state)
10. Usual Occupation: Engineer
11. Industry or business: Seafarer

FATHER
12. Name: Jacob Schriver
13. Birthplace: Pa.

MOTHER
14. Maiden Name: Ellen Unger
15. Birthplace: Pa.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/9/47 (month) (day) (year)
(c) Cemetery or crematory: New Oxford Cem
Location: New Oxford Pa.
18 (a) Funeral director: Wm Cook Inc
(b) Address: 1217 St Paul St
19 (a) (Date rec'd by registrar) (b) Registrar: Huntington Williams, M.D.

JUL 9 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8 1947, at 4:07 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 3 1947, to July 8 1947, and that I last saw h. im alive on July 8 1947.

Immediate cause of death: Squamous cell carcinoma floor of mouth right, with metastasis to right side — Duration: ABOUT 15 yrs.
Due to: of neck and lungs
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon, Clinical Director
Address: US Marine Hospital Date signed: 7/9/47

X

G53323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

G53323
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 626 S. Montford Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Stanley Komorowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Frances Komorowski

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years 48 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Foreman Co.

11. Industry or business Hanover Street

FATHER
12. Name Peter Komorowski
13. Birthplace Poland

MOTHER
14. Maiden Name Marie Wielezyka
15. Birthplace Poland

16 (a) Informant Mrs. Frances Komorowski
(b) Address 626 S. Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 12 1947 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary Cem
Location Mary Dever

18 (a) Funeral director 401 S. Chester St
(b) Address 401 S. Chester Street

19 (d) JUL 9 1947 (Filled in by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1947, at 525 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary occlusion; Hypertrophy and dilatation of the Heart
Due to Chronic rheumatic, mitral and aortic valves
Other Conditions Generalized arterio-sclerosis
(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Tuttle M.D.
Medical Examiner.
Date signed 7-8-47

Guido Trentanove

G53324 ✓ G53324

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town Brooklyn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1428 83rd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Guido Trentanove

3 (b) If veteran, name war

3 (c) Social Security Account No.

Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-8-34

8. AGE: Years 12 | Months — 9 | Days — 6 | If less than one day — hr. — min.

9. Birthplace New York
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Guido Trentanove
13. Birthplace Italy

MOTHER
14. Maiden Name Jenny Lofaso
15. Birthplace Italy

16 (a) Informant Ranalda
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof July 12-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Brooklyn-N.Y.
Location Brooklyn New York

18 (a) Funeral director Ellsworth Funeral Co.
(b) Address 3911 Liberty Heights

19 (a) (Date received by registrar) Huntington Williams M.D.

9-10-47

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-8-47 at 1030 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-8-47 to 7-8-47.
and that I last saw him alive on 7-8 1947.

Immediate cause of death CARDIAC FAILURE — Duration

Due to TETRALOGY OF FALLOT — LIFE

Due to

Other Conditions SURGICAL [redacted]
(Operation within 3 months of death)

Date of operation

Major findings of operation: SAME

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard C. Clay
Address Johns Hopkins Hosp. Date signed 7-[illegible]-47

50

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53325

BALTIMORE CITY HEALTH DEPARTMENT

BC#983553 CERTIFICATE OF DEATH

Registered No. G53325

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution: Church Home & Hospital, Balto 31
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town BALTIMORE Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 2712 Yorkway (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Foust, Baby Boy

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/5/45

8. AGE: Years X Months X Days 2 If less than one day hr. min.

9. Birthplace BALTIMORE, Md (Town, county and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Roy Foust
13. Birthplace Maryland

MOTHER
14. Maiden Name Violet Spangler
15. Birthplace PENNA.

16 (a) Informant Parents
(b) Address 2712 Yorkway, Balto

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JUL 9 1947

18 (a) Funeral director
(b) Address Commissioner of Health

JUL 9 - 1947 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/7 1947 at 7.25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/7 1947 to 7/7 1947 and that I last saw him alive on 7/7 1947.

Immediate cause of death Respiratory Failure

Due to Collapse of Lung

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7/7/47

Major findings of operation: mucous in bronchi

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. J. Kobler, M.D.

Address Church Home & Hosp Date signed 7 July '47

G53326

BHD-82787

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

G53326
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green Street & Lombard.
(c) Hospital or institution:
University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 622 Hanover St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Felder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Negro	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-5-47

8. AGE: Years	Months	Days	If less than one day
		1	23 hr. 40 min.

9. Birthplace Baltimore City Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Richard Felder
13. Birthplace Sumpter, South Carolina

MOTHER
14. Maiden Name Odell Griffin
15. Birthplace Sumpter, S.C.

16 (a) Informant
(b) Address

17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JUL 9 1947

18 (a) Funeral director Commissioner of Health
(b) Address

JUL 9 - 1947 (a) Baltimore, Md.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-6 1947 at 6 20/24 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1947, to July 6 1947, and that I last saw h alive on July 6 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Atelectasis	
Due to Prematurity	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Sr. Felder M.D.
Address University Hospital Date signed July 6 1947

G53327

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

130

Registered No. G53327

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital, Redwood & Greene Sts
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 308 N. Pennsylvania Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Maurice Fauntleroy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male

5. Color or race negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1927

8. AGE: Years 10 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER
12. Name Agus Fauntleroy
13. Birthplace Va.

MOTHER
14. Maiden Name Ethel Pigott
15. Birthplace Va.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JUL 9 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JUL 9 1947 (Date rec'd by registrar) Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/7/47 19 , at 10:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/7/47 19 , to 7/7 1947, and that I last saw him alive on 7/7 19 47.

Immediate cause of death Acute Pericarditis
Heart Failure

Due to Toxic myocarditis

Due to Acute Nephritis

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: Autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D. B. Pigott, M.D.
Address University Hospital Date signed 7/8/47

X

G53328

Amd. 7/16/47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1613

G53328 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5316 Catalpha Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5316 Catalpha Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Evelyn M. Staylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F E Male

5. Color or race White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~ Married

6 (b) Name of husband or wife Charles A. Staylor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 29th 1907

8. AGE: Years 40 | Months 5 | Days 10 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name John F. Sress
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary E. Dennis
15. Birthplace Balto. Md.

16 (a) Informant Chas. A. Staylor
(b) Address 5319 Catalpha Rd.

17 (a) Burial (b) Date thereof 7/12/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Mossland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address St. Paul St.

19 (a) JUL 10 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1947, at 12:15 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, ~~suicide~~ probably homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic pulmonary tuberculosis with cavities

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury 7/6/47 5316 Catalpha Rd M.
(b) Where did injury occur? Baltimore, Md
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Ingestion of caustic

23. Signature Thos. A. Merrill M.D.
Medical Examiner.
Date signed 7-9-47

G53329

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

186a

G53329
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital 11-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 530 N. Charles Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DANIEL T. DEESE

3 (b) If veteran, name war World War 2
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Gerard Deese
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 25 1920

8. AGE: Years 27 | Months 6 | Days 14 | If less than one day ..... hr. ..... min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Teller
11. Industry or business Patapsco Neck Co

FATHER
12. Name Lonnie J. Deese Jr
13. Birthplace North Carolina

MOTHER
14. Maiden Name Ethel Hopkins
15. Birthplace North Carolina

16 (a) Informant Jno H. Deese
(b) Address 530 N Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/11/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ U.S National
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address St. Paul St.

19 (a) JUL 10 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8, 1947, at 1 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured 4th, 5th, 6th cervical vertebrae.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-5-47 at 3.30 P. M.
(b) Where did injury occur? Higgins Beach-Pt. Pleasant Anne Arundel Co. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Dove in shallow water.

23. Signature Howard J. Williams M.D. Medical Examiner.
Date signed 7-8-47

G53330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

CWK-111958

Registered No. G53330

46 M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 7
(If outside city or town limits, write RURAL and give town)
(d) Street No. 458 Macon Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME C
Caroline Buhrman or Bhurman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Josiah (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 16 1867

8. AGE: Years 79 | Months 8 | Days 23 | If less than one day hr. min.

9. Birthplace Pennsylvania (York)
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Martin Fake
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace Pa.

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 7/12/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bethel
Location Highfield, Washington Co. Md

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) JUL 10 1947 Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH July 9 1947, at 8:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1947 to July 9 1947 and that I last saw h. alive on July 9 1947

Immediate cause of death	Duration
Mesenteric Thrombosis	6 days
Due to Arteriosclerosis ?	
G.U. Malignancy ?	
Due to	
Other Conditions Hypertrophic Arthritis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Mesenteric Thrombosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank S. Forster M.D.
Address Baltimore City Hospitals Date signed 7/9/47

X

G53331

G53331 68

BALTIMORE CITY HEALTH DEPARTMENT ✓ G53331

CERTIFICATE OF DEATH 45F

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1030 Augusta St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1030 Augusta St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Soellers

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
no	216-01-7920	Male	White	Married

6 (b) Name of husband or wife Julia A
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8 1876

8. AGE: Years	Months	Days	If less than one day
71	1	1	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Plumber
11. Industry or business

FATHER
12. Name August Soellers
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Unknown
15. Birthplace Germany

16 (a) Informant Julia A Soellers
(b) Address 1030 Augusta St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/12/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Tilhom Bros
(b) Address 2114 E Baltimore St

19 (a) JUL 10 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1947, at 10:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-1-47 19 to 7-9 1947.
and that I last saw h[illegible] alive on 7-9 1947.

Immediate cause of death	Duration
Myocardial Insufficiency	4 day
Due to	
Carcinoma of Throat	3-yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Martin M.D.
Address 1500 N Broadway Date signed July 9 1947

X

G53332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

CWK-111833

Registered No. G53332

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 61 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. ~~XXXXX~~ 2452 Greenmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Krozer Milliman or Miliman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 13-1886

8. AGE: Years 61 | Months 4 | Days 26 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Milliman or Miliman
13. Birthplace Maryland

MOTHER
14. Maiden Name Ella ?
15. Birthplace Delaware

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 7/10/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 JUL 10 1947 (b) Huntington Milliman M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1947, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947, to July 9 1947, and that I last saw h~~im~~ alive on July 9 1947.

	Duration
Immediate cause of death: Malnutrition	18 days
Due to: Chronic Alcoholism	yrs.
Due to:	
Other Conditions: None	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address Balto. Md. Date signed 9 Jul 47

C53333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C53333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp 19-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1522 W. Fairmount
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM (COMANDO) COMMANDER. 20 J.M

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Viola Commander

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business American Paving Co

FATHER
12. Name A. Commander
13. Birthplace N. C.

MOTHER
14. Maiden Name Sarah Hollwell
15. Birthplace N C

16 (a) Informant Viola Commander
(b) Address 1522 W. Fairmount ave

17 (a) Burial (b) Date thereof July 12-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director James A Adams
(b) Address 142 W Biddle St.
(a) (Signature of local registrar) Huntington Williams M.D.

JUL 10 1947

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-8- 1947, at 9:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary artery disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 7/9/47

G53334

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

G53334 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring Ave
(c) Hospital or institution: Levindale
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2300 Edgemont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME SAMUEL S. STARK

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Esther

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 61 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER 12. Name Michael
13. Birthplace Austria

MOTHER 14. Maiden Name unknown
15. Birthplace Austria

16 (a) Informant Esther Stark
(b) Address 2300 Edgemont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-10-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1-29 E Balto St

19 (a) Filed JUL 10 1947 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-9- 1947 at 10'15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-26 1947 to 7-9 1947 and that I last saw h(im) alive on 7-9 1947

Immediate cause of death Carcinoma recti — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Wood M. D.
Address Levindale Home Date signed 7-9-47

G53335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1477

G53335 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~Monument~~ Rutland ave. 1511
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore, Maryland (If outside city or town limits, write RURAL and give town)
(d) Street No. 3717 Columbus Drive #15 (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Potler 83145

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Louis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1908

8. AGE: Years 39 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joe
13. Birthplace Russia

MOTHER
14. Maiden Name Sophie
15. Birthplace Russia

16 (a) Informant Louis Potler
(b) Address 3717 Columbus Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-10-47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Young Mens
Location Windsor Mill Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 1409 E Balto St

19 (a) JUL 10 1947 (Date rec'd by local registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9, 1947, at 5:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 9, 1947 to July 9 1947, and that I last saw her alive on July 9, 1947:

Immediate cause of death	Duration
Pulmonary Embolism	2 hrs.
Pulmonary Edema	2 hrs.
Due to following delivery	
under general anesthesia	
Due to full term normal	over
living male child.	
Other Conditions	10 min.
Pregnancy at term	

(Include pregnancy within 3 months of death)

Date of operation July 9, 1947

Major findings of operation:

How forceps delivery

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph A. Kwint

Address Sinai Hospital Date signed 7/9/47 M. D.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 1062

Registered No. G53336

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LAFAYETTE AND JOHN
(c) Hospital or institution:
WOMAN'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 9

2. USUAL RESIDENCE OF DECEASED:
(a) State CALIF. (b) County VAN NUYS
(c) City or town LOS ANGELES
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4163 LONG RIDGE ESTATES
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME
INEZ LILLIAN COX

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife JAMES JUDSON COX
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) MAY 13, 1918

8. AGE: Years	Months	Days	If less than one day
29	1	26	..... hr. ..... min.

9. Birthplace BELLE CENTER OHIO
(Town, county, and state)
10. Usual Occupation HW
11. Industry or business HOME

FATHER
12. Name WALTER LEO LAMB
13. Birthplace BELLE CENTER OHIO

MOTHER
14. Maiden Name EDITH STUART
15. Birthplace BELLE CENTER OHIO

16 (a) Informant JAMES JUDSON COX
(b) Address LOS ANGELES CALIF

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 11 47 (month) (day) (year)
(c) Cemetery or crematory
Location Bellefontaine Ohio

18 (a) Funeral director John A. Butterelle Sons
(b) Address 1900 Eutaw Place

19 JUL 10 1947 Date received by [illegible] Huntington, W. Va.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 July 1947, at 7:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3 July 1947 to 9 July 1947, and that I last saw her alive on 9 July 1947.

Immediate cause of death	Duration
CARDIO RESPIRATORY FAILURE	30 MIN
Due to CHRONIC ULCERATIVE COLITIS AND	2 YRS
Due to BRONCHIECTASIS, BILAT.	? 11 YRS
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jules B Cox Jr M D
Address Woman's Hospital Date signed 9 July 47

G53337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 63B

Registered No. G53337

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 605 S. Port Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 605 S. Port Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PAULINE ADAMS

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Thomas J. Adams
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 26, 1875

8. AGE: Years	Months	Days	If less than one day
71	9	12	....hr. ....min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Louis Norr
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Berger
15. Birthplace Germany

16 (a) Informant William Adams
(b) Address 3142 Foster Avenue

17 (a) Burial (b) Date thereof 7-12-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mount Carmel
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (Date rec'd by registrar) JUL 10 1947 (b) Huntington Williams, M.D. Address 601 S. Ellwood Ave.

VS 150

MEDICAL CERTIFICATION AM

20. DATE OF DEATH July 8 1947, at 4.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1945 to July 1947
and that I last saw h.. alive on July 8 1947

Immediate cause of death	Duration
Myocardial Failure	2 wks.
Due to Hypertensive Cardio Vascular Disease	5 yrs.
Due to	
Other Conditions Mild Hypothyroidism	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clarence W. LeBrun M.D.
Address 601 S. Ellwood Ave. Date signed 7/8/47

C53338

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. C53338

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3813 Juniper Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 38yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 18
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3813 Juniper Road
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME HERMINE HEGER ALLEN

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Felix Otto Adler
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): March 1, 1880

8. AGE: Years 67 | Months 4 | Days 7 | If less than one day ....hr. ....min.

9. Birthplace: Vienna
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Rudolph Heger
13. Birthplace: Vienna

MOTHER
14. Maiden Name: Not Known
15. Birthplace: Vienna

16 (a) Informant: Mrs. Douglas H. Ford (Daughter)
(b) Address: 3813 Juniper Rd. -18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-10-47 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) Filed July 10 1947 (b) Registrar: Huntington Williams M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8 1947, at 9a M

21. I certify that death occurred on the date above stated; that I attended deceased from July 3 1947, to July 8 1947 and that I last saw h[illegible] alive on July 8 1947

Immediate cause of death: Cerebral Hemorrhage — Duration: 2 hours

Due to:

Due to:

Other Conditions: 6

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Wm. H Pearce M. D.
Address: 2105 St. Charles Date signed: July 9/47

PHYSICIAN
Underline the cause to which death should be charged statistically.

G53339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G53339

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3924 Foster Ave
(c) Hospital or institution: 26-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3924 Foster Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Margaret Burkhardt

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Leo Burkhardt

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Oct 11th 1892

8. AGE: Years 54 | Months 8 | Days 28 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER
12. Name Aug Seifert
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Neuf
15. Birthplace Germany

16 (a) Informant Leo Burkhardt
(b) Address 3924 Foster Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 11th (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location City

18 (a) Funeral director Lillard Funeral Home
(b) Address 2005 Orleans St

19 (a) Filed JUL 10 1947 by registrar Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1947, at 2 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 4 1947, to July 8 1947, and that I last saw h[illegible] alive on July 7 1947.

Immediate cause of death	Duration
(a) Cerebral Hemorrhage	
Due to (b) Hypertension mos	
Due to (c) Arteriosclerosis	
Other Conditions Pyelitis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address 2556 Bolton Date signed July 9 1947

937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53340

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48

Registered No. G53340

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Hilton Road
(c) Hospital or institution: 27
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5214 Cathedral Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helene L Grund

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Wm. H. L. Grund
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23, 1874

8. AGE: Years	Months	Days	If less than one day
73	1	17	hr. min.

9. Birthplace Paris France
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant William H. L. Grund
(b) Address 5214 Cathedral Ave

17 (a) Burial (b) Date thereof 7-11-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md.

18 (a) Funeral director Lazzaro Byers
(b) Address 5005 Park Heights Ave Baltimore, Md.

19 JUL 10 1947
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1947, at 1P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1947, to July 9 1947, and that I last saw h alive on July 8 1947.

Immediate cause of death	Duration
Acute Pulmonary Edema	
Due to Malignancy (Carcinoma of Rectum)	6 months
Due to ?	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation April 10 47
Major findings of operations Carcinoma of Rectum
Gross and Microscopic Findings
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
Signature Michael A. Abrams M. D.
Address 1820 Eutaw Place Date signed July 10 47

VS 150

G53341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

Registered No. G53341

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 21-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 826 N. Ostend Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM BAILEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/11/1914

8. AGE: Years 33 | Months 3 | Days 26 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Sam Bailey
13. Birthplace Md

MOTHER
14. Maiden Name Lottie Porter
15. Birthplace Md

16 (a) Informant Carrie Jordan
(b) Address 713 Eutaw St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/11/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Druid Hill Ave & Mosher St

18 (a) Funeral director Isaiah Brown & Son
(b) Address 1000 Montgomery St

19 (a) JUL 10 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7, 1947, at 11.40 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Stab-wound of brain.
Acute edema of lungs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-4-47 at 608 China St. 3 a. M.
(b) Where did injury occur? Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Sharp instrument

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 7-7-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

G53342 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 11-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 871 Linden Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Alberta Cook.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28, 1865

8. AGE:	Years	Months	Days	If less than one day
	82	0 1	11	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Daniel Garrett
13. Birthplace Howard Co. Md.

MOTHER
14. Maiden Name Martha Waters
15. Birthplace Va.

16 (a) Informant Mr. William Cook
(b) Address 871 Linden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-12-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 JUL 10 1947 (b) Huntington Williams, M.D. Registrar
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/9/47 19 at 8 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/8/47 19 to 7/9/47 19 and that I last saw h alive on 7/9/47 19

Immediate cause of death Intestinal obstruction acute

Due to

Due to

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr I. B. Higgins, M.D.
Address Provident Hosp Date signed 7/10/47

C53343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 931

Registered No. C53343

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1615 W. Saratoga st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 - 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1615 W. Saratoga (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Bailey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Widow

6 (b) Name of husband or wife Josiah Bailey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 16, 1866.

8. AGE: Years	Months	Days	If less than one day
81	3	21	hr. min.

9. Birthplace Harrisburg, Penna. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Walter C. Bailey
(b) Address 1615 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-10-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Kate R Williamson
(b) Address 322 N. Schroeder St.

19. JUL 10 1947 (Date rec'd by Registrar) Huntington Williamson M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1947. at 6:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 25 1947. to July 7 1947. and that I last saw her alive on July 5 1947.

Immediate cause of death	Duration
1 Hypertensive Heart-Disease	7
Due to Arteriosclerosis	
Due to Senility	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Walter Shennington M. D.
Address 2014 Eutaw St. Date signed 7/11/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

G53344 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital 17-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1123 Shields Place
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Stewart

3 (b) If veteran, name war	3 (c) Social Security Account No.
WW II	unknown

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	colored	Widowed

6 (b) Name of husband or wife Henrietta Gaines
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1906

8. AGE: Years	Months	Days	If less than one day
40	11	29	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation truck driver
11. Industry or business

FATHER
12. Name Aron Stewart
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Nellie Williams
15. Birthplace Washington, D. C.

16 (a) Informant Records
(b) Address U.S. Marine Hospital, Balto., Md.

17 (a) Burial (b) Date thereof July 14 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder Sts

19 (a) July 10 1947 Huntington Williams M.D.
(Signature and address of attending physician or medical examiner)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 19 47, at 1:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 27 19 47, to July 9 19 47, and that I last saw h im alive on July 9 19 47.

Immediate cause of death	Duration
Nephritis	One year
Due to uremia, cardiac decompensation	
Due to	
Other Conditions Pulmonary congestion and edema	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Sidney Krohn, S.A.Surg. M. D.
Address U. S. Marine Hospital, Balto., Md. Date signed 6/9/47

X

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53345

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G53345

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3629 Edmondson ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3635 Gelston Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph W. McGrain

3 (b) If veteran, name war None Nov #1
3 (c) Social Security Account No. 105-05-2699

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	Married

6 (b) Name of husband or wife Loretta Schaft
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/21/1895

8. AGE: Years	Months	Days	If less than one day
52	4	14	hr. min.

9. Birthplace Easton Md (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business B & O R R.

FATHER
12. Name John McGrain
13. Birthplace

MOTHER
14. Maiden Name Annie N. Lieber
15. Birthplace Md

16 (a) Informant Mrs J. W. McGrain
(b) Address 3635 Gelston Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/11/47 (month) (day) (year)
(c) Cemetery or crematory Bellemore Memorial
Location Frederick Rd

18 (a) Funeral director J. Fahey & Sons
(b) Address 128 Eager St.

19 (a) (Date rec'd by reg'r) (b) Registrar

JUL 10 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/7 1947, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1940 to 7/7 1947 and that I last saw deceased alive on 7/7 1947.

Immediate cause of death Coronary Thrombosis — Duration 7/7/47
Due to Hypertensive & Arterio-Sclerotic Cardiovascular Dis — 1946
Due to 151 & 337
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thurs E. Pancoast M. D.
Address 3629 Edmondson Date signed 7/8/47

Burlington Williams, Md Registrar

X

Q53346 B# B-77458

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

Registered No. Q53346

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33RD & CHELSEA
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3106 LOCH RAVEN BLVD.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME BABY GIRL PROCTOR

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	SINGLE

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 4-25-47

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace BALTIMORE MD
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER 12. Name NORMAN PROCTOR
13. Birthplace BALTIMORE, MD

MOTHER 14. Maiden Name CATHERINE VIRGINIA JUNG
15. Birthplace BALTIMORE, MD.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location HOSPITAL DISPOSAL

18 (a) Funeral director
(b) Address

19 (a) JUL 10 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH APRIL 21 1947 at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-21 1947 to 4-21 1947 and that I last saw her alive on 4-21 1947

Immediate cause of death	Duration
ASPIRATION	
Due to PREMATURITY	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Malcolm J. Grant M. D.
Address Union Mem. Hosp. Date signed 7/7/47.

DUPLICATE. Original signed by X on 7/24/47
David J. Skeen M.D.

G53347 Birth Certificate

CM. 111810

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

160a

Registered No. G53347

B-83088

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE.
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) N. B.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1904 N. Chester ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fanwell Baby Girl Etta

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30 - 1947

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Edward Atwell
13. Birthplace MD

MOTHER
14. Maiden Name Etta Webster
15. Birthplace VA.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremation (b) Date thereof 7. 3. 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Crematory
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) [illegible] (b) Huntington Williams, M.D.
Registrar

JUL 10 1947

VS 150 Hospital Disposal

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 - 1947, 8.10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 30- 1947, to July -2- 1947, and that I last saw her alive on July- 2 - 1947

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to Prematurity	2 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Prematurity & Cerebral Hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Julian P. Griffin M. D.
Address Balt City Hosp. Date signed 3 July 1947

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G53348 Birth Certificate

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 30F ✓ Registered No. G53348

11169 G-82222

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Mayledt Ave. & Joppa Rd.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME O'Neill, baby girl--Kathryn or O'Niell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	single

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 25, 1947

8. AGE: Years	Months	Days	If less than one day
		1	..... hr. ..... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name Charles Ford
13. Birthplace .....

MOTHER
14. Maiden Name Kathryn O'Neill
15. Birthplace .....

16 (a) Informant Records at Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 7-2-47 (month) (day) (year)
(c) [illegible] or crematory Balto. City Hospitals
Location 4940 Eastern AVE.

18 (a) Funeral director .....
(b) Address .....

19 (a) JUL 10 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150 Hospital Disposal

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26, 1947, at 2:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 25 19 47 to June 28 19 47, and that I last saw her alive on June 26 19 47.

Immediate cause of death ..... Duration
Due to Prematurity ..... 1 day
Due to Congenital Syphilis ..... 5 mos. in utero
Due to .....
Other Conditions .....
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: Cong. Syphilis + Prematurity

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature Julian P. Griffin
Address Balt. City Hosps. Date signed 3 July 47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53349

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G53349 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1919 E. Monument St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1919 E. Monument St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eliza (Lida) Danzeglock

3 (b) If veteran, name war ----

3 (c) Social Security Account No. ----

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wm. Danzeglock

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 27, 1873

8. AGE: Years 73 | Months 9 | Days 11 | If less than one day hr. min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual Occupation: none

11. Industry or business

FATHER
12. Name: Wm. C. Deal
13. Birthplace: Balto Md.

MOTHER
14. Maiden Name: Eliza Duncan
15. Birthplace: Balto. Md.

16 (a) Informant: Wm. Danzeglock
(b) Address: 1919 E. Monument St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 11/47 (month) (day) (year)
(c) Cemetery or crematory: Balto. Cem.
Location: Balto. Md.

18 (a) Funeral director: Philip Henry Sons
(b) Address: 2024 Orleans St.

19 (a) (Date received by registrar) JUL 10 1947 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8/47 19 , at 3 45/A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947 to July 8 1947. and that I last saw h[illegible] alive on July 7 1947.

Immediate cause of death: Cerebral Hemorrhage — Duration 2 days

Due to: Hypertension Paralysis — Duration 5

Due to:

Other Conditions: Hypertension Cardio Vascular disease — Duration 4

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Leonard Bull M. D.
Address 1221 N. Luzerne Ave Date signed July 9, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53350

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G53350

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 Chapel Gate Lane
(c) Hospital or institution: Penncrest Balto. Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) since 7/16/47
(e) Length of stay in Baltimore (yrs., mos., or days) since 7/16/47

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 600 S Chapel Gate Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace E. Cobb

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 011-03-6247

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Edgar W. Cobb

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 8, 1879

8. AGE: Years 67 | Months 11 | Days 1 | If less than one day hr. min.

9. Birthplace Rochester, N. H.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Harry Bickford
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Robert H. Johnson
(b) Address Princess Anne, Md.

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 7/10/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Crematory
Location Cambridge, Mass.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 JUL 10 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/9/ 19 47 at 10:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/6 19 47 to 7/9/ 19 47 and that I last saw her alive on 7/9/ 19 47.

Immediate cause of death: (a) Cerebral Hemorrhage — Duration 3 Wks
Due to Arteriosclerosis
Due to
Other Condition Arteriosclerosis — 7
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dawson P. Glasgow M. D.
Address 3316 Fairfield Ave. Signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

63B

G53351 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Darlington (If outside city or town limits, write RURAL and give town)
(d) Street No. RR #2 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edith E. McNutt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wilton McNutt

6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) 2-25-86

8. AGE: Years 62 | Months — | Days — | If less than one day — hr. — min.

9. Birthplace Delaware (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Victor Bryson
13. Birthplace Md.

MOTHER — 14. Maiden Name Henrietta Harrington
15. Birthplace Md.

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 12 1947 (month) (day) (year)

(c) Cemetery or crematory Darlington
Location Darlington, Harford Co. Md.

18 (a) Funeral director Young Funeral Home
(b) Address Aberdeen Md.

19 (a) July 10 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-9-47 10:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-30 1947 to 7-9-1947 and that I last saw her alive on 7-9-1947

Immediate cause of death: Cardiac failure — Duration

Due to: Gastro Duodenal Ulcer

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry C. Markley M. D.
Address Johns Hopkins Hosp. Date signed 10 July 47

G53352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13/a

G53352 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5301 Edmondson Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28-4
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5301 Edmondson Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Mauk

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Late Mary Mauk
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1, 1863

8. AGE: Years 83 | Months 7 | Days 8 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Shoe Maker

FATHER
12. Name Mauk
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Minnie Lauer
(b) Address 5301 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 12/47. (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd.

18 (a) Funeral director Harry A. Smith
(b) Address 4101 Edmondson Ave.

19 JUL 10 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9/47. 19 , at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 14 1942 to July 4 1947 and that I last saw h. alive on July 9 1947.

Immediate cause of death: Coronary Embolism — Duration: 15 min.
Due to: Cardio-Vascular-Renal Disease — 2 yrs?
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edgar Eltman
Address 803 22nd Ave Catonsville 28 Md. Date signed 7-9-47 M.D.

G53353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G53353

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 629 N. Paca St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 629 N. Paca St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Esther Lecato Fisher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 23, 1904

8. AGE: Years	Months	Days	If less than one day
32	8	17	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Chambermaid

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Agnes Jackson
(b) Address 629 Paca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-12-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 (a) JUL 10 1947 (Date received by registrar) Hunterton Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9, 1947 8a.m. 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19..., to 19..., and that I last saw h... alive on 19....

Immediate cause of death — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature ... M. D.
Address ... Date signed

X

WRIGHT

G53354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Register G53354

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 920 Bentalou St.
(c) Hospital or institution: No

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 920 Bentalou St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel Bell Wright

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Chas C. Wright
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) 12/15/1890

8. AGE: Years 56 | Months 6 | Days 23 | If less than one day hr. min.

9. Birthplace Carroll Co.
(Town, county, and state)
10. Usual Occupation Home Wife
11. Industry or business Own

FATHER
12. Name Otho A. Fleming
13. Birthplace Carroll Co.

MOTHER
14. Maiden Name Cordelia Mullinix
15. Birthplace Carroll Co.

16 (a) Informant Edward Wright
(b) Address 920 Bentalou St.

17 (a) Burial (b) Date thereof 7-11-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Taylorsville
Location Taylorsville, Bragg Co. Md.

18 (a) Funeral director C. M. Walts
(b) Address Winfield, Md

19 (a) JUL 10 1947 Huntington Williams M.D.
(Date received by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1947 at 2 AM

21. I certify that death occurred on the date above stated, that I attended deceased from June 10 1947 to July 8 1947 and that I last saw her alive on July 8 1947

Immediate cause of death
Carcinoma Uterus
Duration 3 yr.
Due to Bladder Involvement
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry C. Hoyt M.D.
Address 1923 W. Mount Lane Date signed July 10 1947

G53355

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G53355
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1006 Bentalou St.
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 Bentalou St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Belle M. Young

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Nathan E. Young deceased

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 6-29-1867

8. AGE: Years 80 | Months 0 | Days 9 | If less than one day ... hr. ... min.

9. Birthplace Howard Co. Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Chas. T. Mullinix
13. Birthplace Maryland

MOTHER
14. Maiden Name Polly Penn
15. Birthplace Maryland

16 (a) Informant Richard E. Young
(b) Address 1006 Bentalou St. Md.

17 (a) Burial (b) Date thereof 7-11-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Pine Grove
Location Mt. Airy, Carroll Co. Md.

18 (a) Funeral director E. W. Waetz
(b) Address Winfield Md

19 JUL 10 1947 (b) Washington-Williams, M.D.
(Date rec'd by Registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1947, at 6:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1947, to July 7 1947, and that I last saw her alive on July 7 1947.

Immediate cause of death: Coronary Occlusion.
Due to Cerebral Sclerosis.
Due to Senile debility

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bv L. Freund M.D.
Address 232 E Pennsylvania Ave Date signed 7-8-47

G53356

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1218

Registered No. G53356

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Univ. Hosp.

(c) Hospital or institution: Baltimore, Md.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balto Co

(c) City or town Essex

(If outside city or town limits, write RURAL and give town)

(d) Street No. 532 Eastern Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Grace E. Hart

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife John R. Hart

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1891

8. AGE: Years 55 | Months 7 | Days 5 25 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Grech
13. Birthplace Germany

MOTHER
14. Maiden Name Carrie Alochinsky
15. Birthplace Europe

16 (a) Informant Mr. John R. Hart

(b) Address 532 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-11-47 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Essex, Md.

18 (a) Funeral director John J. Connelly

(b) Address 4 Eastern Ave

19 (a) JUL 10 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/8 1947, at 5:10 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/12 1947 to 7/8 1947, and that I last saw h.as. alive on 7/8 1947

Immediate cause of death	Duration
Cardio-respiratory Collapse	
Due to Uraemia	
Due to Chronic nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature David J. Phillips M. D.

Address University Hosp. Date signed 7/8/47

G53357

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G53357

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 512 Styles Ste
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 512 Styles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie Lewis

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C.	Widowed

6 (b) Name of husband or wife "
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 30 1855

8. AGE: Years	Months	Days	If less than one day
60	9	21	hr. min.

9. Birthplace Balto
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Lewis
13. Birthplace Balto.

MOTHER
14. Maiden Name Margaret Lewis
15. Birthplace Balto

16 (a) Informant Friends
(b) Address

17 (a) Burial (b) Date thereof 7 11 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Carlton Cem
Location Balto, Md.
18 (a) Funeral director Joseph S. Lock Jr.
(b) Address 1364 Central Ave.
19 (a) JUL 10 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1947, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1947, to July 1947, and that I last saw her alive on July 7 1947

Immediate cause of death Cardiac

Due to Hypertension

Due to

Other Conditions Edema of lungs
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Gilpert
Address 915 Stiles St Date signed 7/10/47 M. D.

VS 150

G53358

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 457

G53358
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 524 days
(e) Length of stay in Baltimore (yrs., mos., or days): 524 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: NY (b) County:
(c) City or town: Brooklyn (If outside city or town limits, write RURAL and give town)
(d) Street No.: 9 Sta. Charles Place (If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country:

3 (a) FULL NAME: Patrick Mc Grath

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: --

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Anne Legney McGrath
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.): Dec. 27, 1878

8. AGE: Years 68 | Months 7 6 | Days 15 14 | If less than one day: hr. min.

9. Birthplace: ? Ireland (Town, county, and state)
10. Usual Occupation: Stoker
11. Industry or business: Merchant Seaman

FATHER
12. Name: Patrick Mc Grath
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Margaret Milton
15. Birthplace: Ireland

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7-10-47 (month) (day) (year)
(c) Cemetery or crematory: Holy Cross
Location: Brooklyn N. Y. New York
18 (a) Funeral director: Daly & Roberts Funeral Home Inc
(b) Address: 403 E. 25th St.
19 (a) Huntington Williams, M.D. (Date received by registrar) Registrar
JUL 10 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 10 1947, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1 1946, to July 10 1947, and that I last saw him alive on July 10 1947.

Immediate cause of death: Carcinoma squamous cell, right alveolar ridge with extension to mandible and neck — Duration: More than 6 yrs.
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: William A. Nelson
Wm. A. Nelson, Asst. Surgeon (R) M. D.
Address: US Marine Hospital Date signed: 7/10/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C53359

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C53359

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2675 St. Benedict Street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) -

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2675 St. Benedict Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie Edna Prior

3 (b) If veteran, name war: no

3 (c) Social Security Account No. no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Joseph Bennett

6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) May 24.

8. AGE: Years	Months	Days	If less than one day
62	1	16	..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Franklin Cowen

13. Birthplace Unknown

MOTHER 14. Maiden Name Eliza Virginia Durham

15. Birthplace Maryland

16 (a) Informant Willard E. Prior

(b) Address 2675 St. Benedict St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 12 (month) (day) (year)

(c) Cemetery or crematory Cemetary

Location Loudon Park

18 (a) Funeral director Wm. Cook, Inc.

(b) Address 1217 St. Paul Street

19 (Date rec'd by registrar) JUL 11 1947 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1947, at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/5 1947, to 7/9 1947, and that I last saw h[illegible] alive on 7/9 1947.

Immediate cause of death: Coronary Occlusion with Cardiac Failure.

Due to Arteriosclerosis

Due to Hypertension

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
?
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Williamson M.D.

Address 3325 Frederick Ave Date signed 7/10/47

VS 150

G53360

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

12/a

Registered No. G53360

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1138 Harford Avenue
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) -

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1138 Harford Avenue (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine (Kate) S. Morrison

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 15, 1876

8. AGE: Years 70 | Months 10 | Days 25 26 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation -

11. Industry or business

FATHER
12. Name John Hubbard
13. Birthplace Baltimore

MOTHER
14. Maiden Name Camelia Seward
15. Birthplace Maryland

16 (a) Informant Hazel M. Brohawn
(b) Address 1138 Harford Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 12- (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Baltimore

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) 7/11/1947 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1947, at 6:15AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/9 1947 to 7/10 1947, and that I last saw her alive on 7/10 1947.

Immediate cause of death: Coronary Thrombosis — Duration: minutes
Due to: Cardiovascular Renal Disease — 10yrs
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Friedman
Address 1206 E. Preston St. Date signed 7/10/47 M. D.

G53361

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G53361

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County [illegible]
(c) City or town Green Haven, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3rd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Jacobson

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10, 1863

8. AGE: Years	Months	Days	If less than one day
84	4	-	hr. min.

9. Birthplace St. Louis
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Louis Klingelhofer
13. Birthplace ✓

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant [redacted] Mary Yeatman
(b) Address 3rd St. Green Haven, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/14/47 (month) (day) (year)
(c) Cemetery or crematory Oaklawn Cem.
Location Eastern Ave.

18 (a) Funeral director Howard M. Blight Jr.
(b) Address 4914 Belair Road

19 JUL 11 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1947, at 345 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 9 1947, to July 10 1947, and that I last saw h[illegible] alive on July 10 1947.

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to arteriosclerosis & hypertension	
Due to	
Other Conditions Diabetes mellitus	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. C. Duvall Jr. M. D.
Address Date signed

VS 150

82a

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53362

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G53362 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1111 N.Lakewood Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1111 N.Lakewood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Edward Thomas Mersman

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No. 218-05-3635

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10,1895

8. AGE: Years 52 | Months 12 | Days 0 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business Emerson Hotel

FATHER
12. Name Frederick Mersman
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Katherine Catiz
15. Birthplace Balto. Md.

16 (a) Informant Mrs.Mary Nelson
(b) Address 1111 Nlakewood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 12/47 (month) (day) (year)
(c) Cemetery or crematory U.S.Nat.Cem.
Location Balto, md.

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

19 (a) Filed July 11 1947 (b) Recorded by Registrar [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10/47 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1947 to July 10 1947 and that I last saw him alive on July 8 1947.

Immediate cause of death: Coronary Thrombosis — Duration: 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas H. Lane M.D.
Address 2607 E. Pratt Date signed 7-11-47

VS 150

G53363 ShinaBerry G53363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Balto Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1603 Clayton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Ira S. Shinaberry

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: ELLA (REED)
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) OCT 26, 1882

8. AGE: Years 64 | Months 8 | Days 15 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business ABRAHAM

FATHER — 12. Name Ira Shinaberry
13. Birthplace WEST VIRGINIA

MOTHER — 14. Maiden Name — BUSSARD
15. Birthplace WEST VIRGINIA

16 (a) Informant Floyd Shinaberry
(b) Address 22½ E. Barney St

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7 12 47 (month) (day) (year)
(c) Cemetery or crematory [illegible]
Location RITCHIE HIGHWAY

18 (a) Funeral director JOHN F. DENNY, INC.
(b) Address 715 LIGHT ST.

19 7-11-1947 (Date received by Local Registrar) (b) Huntington Williams, M.D. Registrar

VS 150 Upper.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1947, at 10:39 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1947, to July 10 1947, and that I last saw h[illegible] alive on July 10 1947.

Immediate cause of death: Cerebral hemorrhage — Duration: 1 hr

Due to: Hypertensive cardio vascular disease and

Due to: arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence July 9 1947 at 9:30 P M
(c) Where did injury occur? Baltimore City (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? no
(e) Means of injury: [illegible] fell down stairs

23. Signature Harold Feldman M. D.
Address So. Balto Gen Hosp Date signed July 11

Howard J. Mahoney, Jr. M.D.

G53364

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1484

Registered No. G53364

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7
(c) Hospital or institution: Union Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Biello
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1016 N. appleton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willie May Hunt 48775

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	colored	married

6 (b) Name of husband or wife John E. Hunt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 24, 1916

8. AGE: Years	Months	Days	If less than one day
31	5	15	hr. min.

9. Birthplace S.C.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Thomas
13. Birthplace Norfolk Va

MOTHER
14. Maiden Name Lee Martin
15. Birthplace Greenville S C

16 (a) Informant John E Hunt
(b) Address 1016 N Appleton St

17 (a) Burial (b) Date thereof July 13. 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenville S.C
Location Greenville County

18 (a) Funeral director Joseph A Sisely
(b) Address 661 West Lane St

19 (a) JUL 11 1947 Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-9-47 1947, at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-6 1947 to 7-9 1947; and that I last saw her alive on 7-9-47 19

Immediate cause of death Toxemic Shock following preeclampsia — Duration

Due to Pregnancy

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7-9-47

Major findings of operation: Full Term female Child

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. R. Hahn M. D.
Address Union Hosp Date signed 7-9-47

over

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered No. G53365

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 615 Avondale RD (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Gordon Collins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race N

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Elizabeth Collins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/14/47 (1947)

8. AGE: Years 40 | Months 5 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore, MD (Town, county, and state)

10. Usual Occupation Maintenance Man

11. Industry or business

FATHER
12. Name William Collins
13. Birthplace Md

MOTHER
14. Maiden Name Edna Brown
15. Birthplace Md

16 (a) Informant Elizabeth Collins
(b) Address 615 Avondale Rd

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 7-12-47 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Balto. Md.

18 (a) Funeral director Samuel W. Sullivan Jr.
(b) Address 1011 N Arlington Ave

19 JUL 11 1947 (Date received) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/9 19 47 at 4:48 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death Pneumonia — Duration

Due to Hemorrhage Hemorrhage

Due to

Other Conditions Hypertension 1 yr

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address 1153 Hale Date signed 2/9/47

VS 150

G53366

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 1248

G53366

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1417 W Lafayette
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eleanor W. Morris (Mons)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: George Wm.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-28-1900

8. AGE: Years 47 | Months 1 | Days 12 | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Lish Davenport
13. Birthplace Va.

MOTHER
14. Maiden Name Julia Jackson
15. Birthplace Va.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 7-13-47 (month) (day) (year)
(c) Cemetery or crematory Sugar Hill
Location Boyce Va.

18 (a) Funeral director Samuel W. Sullivan
(b) Address 1011 N. Arlington Ave

19 JUL 11 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1947, at 2 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 28 1947, to July 10 1947, and that I last saw him alive on July 10 1947

Immediate cause of death	Duration
Acute Lobar Pneumonia	6 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.
Address Date signed 1947

G53367 1/2 — BALTIMORE CITY HEALTH DEPARTMENT — G53367 Registered No. 1/2 G53367

CERTIFICATE OF DEATH 1362

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 922 N. Bellevue Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 922 N. Bellevue Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bernard L. Burky

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 23 1910

8. AGE: Years 36 | Months 10 | Days 16 17 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER — 12. Name Henry G. — 13. Birthplace Baltimore

MOTHER — 14. Maiden Name Catharine Gabert — 15. Birthplace Baltimore

16 (a) Informant Henry G. (b) Address 922 N Bellevue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 12 47 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet
Location Balto Md

18 (a) Funeral director Frank Shockley
(b) Address 900 N Eutaw St

19 (a) July 11 1947 (Date) Huntington Williams, M Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1947 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 4 1947 to July 9 1947 and that I last saw h[illegible] alive on July 9 1947

Immediate cause of death	Duration
Pulmonary Tuberculosis	4 mos
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Pokorny M.D.
Address 2200 E Madison St Date signed 7/11/47

G53368
516392.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 467

G53368
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Every correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2445 Eutaw St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eugene Bartlett

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Black
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife: Alma.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-24-92

8. AGE: Years 54 | Months 11 | Days 16 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Plumber
11. Industry or business

FATHER
12. Name ? ?
13. Birthplace ?

MOTHER
14. Maiden Name Sadie Bartlett
15. Birthplace Va.

16 (a) Informant Reinds.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-12-47 (month) (day) (year)
(c) Cemetery or crematory U.S. Bells National
Location Balto National

18 (a) Funeral director Rayner Sanders
(b) Address 1112 E Preston St

19 (a) JUL 11 1947 (Date rec'd by registrar) (b) Huntingtown Millersville, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1947, at 12.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1947 to July 9 1947 and that I last saw him alive on July 9 1947.

	Duration
Immediate cause of death: Pulmonary embolism	
Due to: Thrombophlebitis	
Due to: Carcinoma rectum	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 6/25/47 6/29/47
Major findings of operation: rectum & Metastasis
of autopsy

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Michael C. Sexton
Address Johns Hopkins Hospital Date signed July 11 1947
Balto Md - X

G53369

CWK-111986

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1937

G53268 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 81 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2129 Llewelyn Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Woodrum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 3-1899

8. AGE: Years 47 | Months 10 | Days 7 | If less than one day ..... hr. ..... min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jack Epps
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Epps
15. Birthplace Virginia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 7-12-47 (month) (day) (year)
(c) Cemetery or crematory
Location Bel Kesrell Virginia

18 (a) Funeral director Rayner & Sanders
(b) Address 1412 E. Preston St

19 (a) JUL 11 1947 (Date received by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 19 47, at 1:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 8 19 47, to July 10 19 47, and that I last saw h. alive on July 10 19 47.

Immediate cause of death: Cerebral Hemorrhage, Rt. — Duration: 5 Days
Due to Hypertension
Due to
Other Conditions Hypertension Heart Disease
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. E. Robinson Jr. M. D.
Address Balt City Hosp Date signed 7/10/47

83a

653370 JL - 112056 BALTIMORE CITY HEALTH DEPARTMENT 653370
CERTIFICATE OF DEATH
83B Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2h. 15m.
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 235 N. Chester St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Katzoff

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Joseph
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr): ? ? ?
8. AGE: Years: 69 ? Months: Days: If less than one day hr. min.
9. Birthplace: Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name: Isreal Caplan
13. Birthplace: Russia

MOTHER
14. Maiden Name: ?
15. Birthplace: Russia

16 (a) Informant: B. C. H. Records
(b) Address: 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-11-47 (month) (day) (year)
(c) Cemetery or crematory: Rosedale
Location: Philadelphia Rd & Hamilton Ave

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 1496 Baltimore Pike Huntington & Williams

19 (a) Date received by Registrar: JUL 11 1947 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 19 47, at 7.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 19 47 to July 10 19 47, and that I last saw h er alive on July 10 19 47.

Immediate cause of death: Cerebral Thrombosis — Duration: 1 day
Due to: Hypertension
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature: W. R. Hazzard M. D.
Address: Balto City Hosp. Date signed 7-10-47

G53371

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 95c

Registered No. G53371

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
~~(c) Hospital or institution:~~
120 N. Asquith St. 51
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 120 N. Asquith St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK MORTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 20

8. AGE: Years 43 | Months 9 | Days 17 | If less than one day hr. min.

9. Birthplace New York N. Y.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Morton
13. Birthplace Boyaton Va

MOTHER
14. Maiden Name Rebbca Gayle
15. Birthplace Boyaton Va

16 (a) Informant Henry Morton
(b) Address 255 W. 121 St N.Y. N.Y

17 (a) Burial (b) Date thereof JUL 12-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem
Location Brooklyn N.Y.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley ave

19 (a) JUL 11 1947 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1947, at 6:15 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute dilatation of heart
Acute edema of lungs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George E. Merrill M.D.
Medical Examiner.
Date signed 7/8/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G53372

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 422 N. Chapple St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 d
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 422 N. Chapple St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cora Nelson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Archie Nelson

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) June 11-1897

8. AGE: Years 50 | Months - | Days 26 | If less than one day ..... hr. ..... min.

9. Birthplace Iowa (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Jacob Jefferson

13. Birthplace Iowa

MOTHER 14. Maiden Name Mary Ann Jefferson

15. Birthplace Iowa

16 (a) Informant Archie Nelson

(b) Address 422 N. Chapple St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 11-1947 (month) (day) (year)

(c) Cemetery or crematory Mt Calvery Cem

Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Bleuthy Ave

19 JUL 11 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1947 at 8 25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/20 1946 to 7/7 1947 and that I last saw h alive on 7/6 1947.

Immediate cause of death Carcinomatosis | Duration

Due to Carcinoma of Cervix | approx. 1 yr

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Raynel Brown

Address 1500 E. Madison St Date signed 7/10/47

Raynel Brown

G53373

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G53373

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3623 Gelston Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 4 Mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3623 Gelston Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Laird

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife late Geo. Laird
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 27, 1867

8. AGE: Years 80 | Months 3 | Days 14 | If less than one day 15 hr. min.

9. Birthplace Scotland (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name James Ross
13. Birthplace Scotland

MOTHER 14. Maiden Name Margaret Mc Gregor
15. Birthplace Scotland.

16 (a) Informant Mrs. Jeanie Bowen
(b) Address 3623 Gelston Ave.

17 (a) Removal (b) Date thereof 7/11/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Wilson Cemetery
Location Graphitville Baltimore

18 (a) Funeral director Harry H. Knight
(b) Address 410 E Edmondson Ave

19 JUL 11 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1947, at 7:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 30 1947, to July 11 1947, and that I last saw h[illegible] alive on July 11 1947.

Immediate cause of death
Cardiac asthenia
Due to Myocardial degen.
Due to Chronic Hemorrhage Cardio Vascular
Due to Anemia.

Duration: 2 yrs. 17 & 8 mos. 10 yrs.

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. W. Toomey M.D.
Address 1202 St Paul St Date signed 7-11-47 M. D.

G53374

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

9-27

Registered No. G53374

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [redacted]
(c) Hospital or institution: Union Memorial Hospital, Baltimore Md
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 426 East Lake Ave (If rural, give location) LAKE.
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Emma Malcolm~~ PARKER (EMMA) Emma Rebecca Parker

3 (b) If veteran, name war	3 (c) Social Security Account No.
NONE	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Malcolm Parker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1874

8. AGE: Years	Months	Days	If less than one day
73	0	9+0	hr. min.

9. Birthplace Baltimore md.
(Town, county, and state)
10. Usual Occupation NONE
11. Industry or business NONE

FATHER
12. Name Edwin Mooves
13. Birthplace

MOTHER
14. Maiden Name Emma Griffith
15. Birthplace

16 (a) Informant Mr. Llewellyn Parker
(b) Address Upton Md 4

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7-12-47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Pk. Cem.
Location Woodlawn - md.

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. MOWEN SUC.) 100 W. NORTH AVENUE

19 JUL 11 1947 (Date rec'd by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-10 1947, at 8:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-8 1947, to 7-10 1947, and that I last saw her alive on 7-10 1947.

Immediate cause of death	Duration
Cardiac failure	3d
Due to Arteriosclerotic	
Due to Heart disease	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address [redacted] Date signed 7-9-47

VS 150

G53375

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. G53375

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5003 Govane Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 10
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5003 Govane Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM C. ZIMMERMAN

3 (b) If veteran, name war: none
3 (c) Social Security Account No.:

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ruby E. Zimmerman
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Aug. 31, ~~1880~~ 1881

8. AGE: Years ~~66~~ 65 | Months 10 | Days 9 10 | If less than one day: hr. min.

9. Birthplace: Baltimore
(Town, county, and state)

10. Usual Occupation: Clothing Cutter

11. Industry or business: Goldman Co.

FATHER
12. Name: John C. Zimmerman
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Susan F. Askey
15. Birthplace: Balto., Md.

16 (a) Informant: Mrs. Ruby Zimmerman
(b) Address: 5003 Govane Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/14/47 (month) (day) (year)
(c) Cemetery or crematory: Hampstead
Location: Hampstead, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) JUL 11 1947 (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10, 1947, at 5:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1947 to July 10 1947 and that I last saw him alive on July 9 1947.

Immediate cause of death: Coronary occlusion — Duration:
Due to: Coronary Thrombosis
Due to: Coronary Sclerosis
Other Conditions: Arterio-Sclerosis
Pulmonary Infarctions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter A. Anderson M. D.
Address 3061 Shannon Drive Date signed July 10-47

G53376

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

G53376

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene.
(c) Hospital or institution: Univ.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Towson (If outside city or town limits, write RURAL and give town)
(d) Street No. 500 W Joppa Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FANNIE R. JOHNSON

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband ~~or wife~~ Joseph Z. Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16, 1872

8. AGE: Years 74 | Months 7 | Days 24 | If less than one day: hr. min.

9. Birthplace Boston, Georgia (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name Burton Hicks

13. Birthplace Ga.

MOTHER 14. Maiden Name Eliz. Daniels

15. Birthplace Ga.

16 (a) Informant Mrs. Sam. B. Smith

(b) Address 500 W. Joppa Rd. Towson

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/11/47 (month) (day) (year)

(c) Cemetery or crematory

Location Oxford, Ga.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) JUL 11 1947 (Date rec'd by registrar) [illegible] Washington Metropolitan [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1947, at 7 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 8 1947 to July 10 1947, and that I last saw her alive on July 10 1947.

Immediate cause of death CIRCULATORY AND Respiratory Collapse — Duration

Due to Pneumonia

Due to

Other Conditions Chronic lymphoid leukemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sidney D. Sachs

Address University Hosp. Date signed 7/10/47 M.D.

1092

G53377

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117a

Registered No. G53377

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton + Wilkens Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Orchard Beach Md
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leo Scanlon.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Bessie L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 31. 1896

8. AGE: Years 50 | Months 11 | Days 9 | If less than one day ..... hr. ..... min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Gas + Elec Co.

11. Industry or business

FATHER 12. Name John
13. Birthplace Md

MOTHER 14. Maiden Name Josephine Price
15. Birthplace Md

16 (a) Informant Hosp. Records
(b) Address

17 (a) Burial (b) Date thereof 7-12-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location A. G. C. Md.

18 (a) Funeral director Flynn + Flynn
(b) Address 1426 Light St.

19 (a) (b) Huntington Williams, M.D.

JUL 11 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1947 at 1:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6 [illegible] 19 47 to 7/9 19 47 and that I last saw h[illegible] alive on 7/9 19 47.

Immediate cause of death Cardiac failure

Duration

asphyxia (gastric)

Due to Pulmonary Embolism

Due to Obstruction, jejunum

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 6/26/47

Major findings of operation: Pylorus obstruction, jejunum

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D W Murphy M.D.
Address St Agnes Date signed 7/9/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53378

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No. G53378

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4676 Pimlico Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4676 Pimlico Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Truman M. Sindall

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Married

6 (b) Name of husband or wife Lillian A. Hess
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 6, 1881

8. AGE: Years	Months	Days	If less than one day
65	9	9	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Oyster Man Foreman

11. Industry or business Wm Lanahan & Bro

FATHER
12. Name Geo. M. Sindall
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary Jones
15. Birthplace Baltimore Md.

16 (a) Informant Mrs Lillian A. Sindall
(b) Address 4676 Pimlico Road.

17 (a) Burial (b) Date thereof 7-12-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director Lorenz Bayard
(b) Address 5005 Liberty Heights Ave
Baltimore, Md.

(Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1947, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 1947, to July 10 1947, and that I last saw him alive on July 9 1947.

Immediate cause of death Coronary Thrombosis — Duration 57 days

Due to

Due to

Other Conditions Mitral regurg. Fatal 57 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. L. De Barbieri M. D.
Address 4723 Park Heights Ave. Date signed 7/10/47

Jesse Hollingsworth X ✓

G53379

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G53379 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 Butler Rd.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 74yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt Co.
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 27 Butler Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jesse Hollingsworth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Katherine B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 29-1872

8. AGE: Years	Months	Days	If less than one day
74	10	12 13	hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER 12. Name John H Hollingsworth

13. Birthplace Balto Co.

MOTHER 14. Maiden Name Kattie E Price

15. Birthplace Md.

16 (a) Informant Mrs Th. A. Davis Jr.

(b) Address Glyndon Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 14-47 (month) (day) (year)

(c) Cemetery or crematory Reisterstown Methodist

Location Balto Co.

18 (a) Funeral director J F Pleine & Sons

(b) Address Reisterstown Md

19 (a) Filed [illegible] 1947 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 Feb 1947 at 1 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 Feb 1947 to 11 Feb 1947 and that I last saw h[illegible] alive on 11 Feb 1947

Immediate cause of death Cardiac Failure — Duration

Due to Intestinal obstruction

Due to Carcinoma of the Sigmoid

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8 July 1947

Major findings of operation: Cancer of Sigmoid

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Marshall K Edwards M.D.
Address Date signed 11 Feb 47

X

G53380

BALTIMORE CITY HEALTH DEPARTMENT X G53380 Registered No.

CERTIFICATE OF DEATH 93

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Lincoln Ave.
(c) Hospital or institution: Maryland Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville #28 (If outside city or town limits, write RURAL and give town)
(d) Street No. 10 Newburg Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Edith H. Jones

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: W
6 (a) Single, ~~married, widowed, or divorced~~: Single
6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7 Feb. 1873

8. AGE: Years 74 | Months 5 | Days 3 | If less than one day ... hr. ... min.

9. Birthplace Catonsville Balto Co. Md (Town, county, and state)

10. Usual Occupation Household Duties

11. Industry or business

FATHER
12. Name Reuben Jones
13. Birthplace Catonsville Md

MOTHER
14. Maiden Name Julia W. Thomas
15. Birthplace Oliverton, Baltimore

16 (a) Informant Miss Florence Jones
(b) Address 10 Newburg Ave Catonsville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/14/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Frederick Ave Balto Md

18. (a) Funeral director Easton Sons
(b) Address 105 Frederick Ave Balto 29 Md

19. (a) (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 July 1947, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8 July 1947 to 10 July 1947, and that I last saw h.C.R alive on 10 July 1947

Immediate cause of death: Possibly a massive cerebral hemorrhage — Duration:
Due to: Hypertension / Cardio vascular disease
Due to:
Other Conditions: Intestinal obstruction
(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. T. McGowan M. D.
Address Md. Gen. Hospital Date signed 10 July 1947

G53381

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G53381
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2910 Dillon St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2910 Dillon St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Ellen Ayres

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Wm. Samuel Ayres
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 15, 1869

8. AGE: Years 77 | Months 10 | Days 25 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Henry Webb
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Jane Harris
15. Birthplace Maryland

16 (a) Informant Mrs. Melvin C. Ayres
(b) Address 2910 Dillon St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 12, 1947 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Govans Md

18 (a) Funeral director E. Millis Lamoreaux
(b) Address 1003 W. Baltimore St

19 (a) July 11 1947 (Date rec'd by registrar) Huntington Williams

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1947, at 8:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to July 10 1947, and that I last saw her alive on July 10 1947.

Immediate cause of death	Duration
Congestive Heart Failure	4 mo.
Due to Arteriosclerotic Cardio Vascular disease	3 yrs.
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. Allatt M. D.
Address 2612 Eastern Ave Date signed 7/10/47

Baltimore 24, Md. X

G53382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 162

G53382
Registered No.

PLEASE WRITE PLAINLY, WITH UNPADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert Street
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 days

2. USUAL RESIDENCE OF DECEASED:
(a) State D. C. (b) County
(c) City or town WASHINGTON D.C.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1451 PARK ROAD, N.W. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Mary M. Schernhorn

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 5, 1867

8. AGE: Years	Months	Days	If less than one day
80	4	6	hr. min.

9. Birthplace ~~[illegible]~~ Washington D.C. (Town, county, and state)

10. Usual Occupation ~~[illegible]~~ Housekeeper

11. Industry or business

FATHER
12. Name George SCHERNERHORN
13. Birthplace NEW YORK

MOTHER
14. Maiden Name CATHERINE DOHERTY
15. Birthplace IRELAND

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 21, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Washington D.C.

18 (a) Funeral director S. H. Hines Co.
(b) Address 14th & Harvard Sts. N.W. Wash. D.C.

19 Date rec'd by Registrar JUL 11 1947 (b) Thurlington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 JULY 1947 at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 21 1947 to July 11 1947 and that I last saw her alive on July 11 1947.

Immediate cause of death Cardiac failure
Sinility

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. Elden H. Perty M. D.
Address Mercy Hospital Date signed 7/11/47

G53383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH . 12 B

Registered No. G53383

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1511 N. Bond Street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) -
(e) Length of stay in Baltimore (yrs., mos., or days) -

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1511 N. Bond Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Charles F. Reiter, Sr.

3 (b) If veteran, name war	3 (c) Social Security Account No.
Yes-World War #1	218 14 0773

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Clara M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1898

8. AGE: Years	Months	Days	If less than one day
48	10	8	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Street Car Conductor
11. Industry or business

FATHER
12. Name Henry F. Reiter
13. Birthplace Alase, Lorraine

MOTHER
14. Maiden Name Marie E. Dumer
15. Birthplace Fullerton, Md.

16 (a) Informant Clara Reiter
(b) Address 1511 N. Bond Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 14 (month) (day) (year)
(c) Cemetery or crematory National
Location Baltimore

18 (a) Funeral director Wm. Cook, Inc.
Address 1217 St. Paul Street

19 (a) JUL 12 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1945 to July 10 1947 and that I last saw h alive on July 3 1947.

Immediate cause of death: Cardiac Arrhythmia

Due to Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 2 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. F. Dandorne M. D.
Address 20 Randall St Date signed 7/10/47

G53384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 937

Registered No. G53384

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Sorrento Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8727 Old Harford Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Francis Bauscher

3 (b) If veteran, name war: W
3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Emma J. Bauscher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 3rd 1853

8. AGE: Years	Months	Days	If less than one day
63	7	27	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Minister

FATHER
12. Name William Bauscher
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Tuttle
15. Birthplace Md.

16 (a) Informant Emma J. Bauscher
(b) Address 8727 Old Harford Rd.

17 (a) Burial (b) Date thereof 7/14/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 JUL 12 1947 (Date rec'd by local reg.) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10th 1947, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1947 to July 10 1947, and that I last saw him alive on July 10 1947.

Immediate cause of death	Duration
Coronary Embolism	
Congestive Heart Failure	24 hrs.
Due to Hypertension Cardiovascular disease.	
Due to Hemiplegia (1 year)	
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward Martin Jr
Address 1933 W. Balto St. Date signed 7/11/47 M. D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. G53385

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1120 St. Paul st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1120 St. Paul st. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Robert Schley

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-0502

4. Sex: Male

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife: Caroline M. Schley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 4th 1887

8. AGE: Years 60 | Months 4 | Days 6 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business P. C. Dugan & Nephew

FATHER
12. Name Jacob S. Schley
13. Birthplace Md.

MOTHER
14. Maiden Name Mar Louise Harrison
15. Birthplace Md.

16 (a) Informant Mrs Caroline M. Schley
(b) Address 1120 St. Paul st.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 7/14/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cedar Hill
Location a. a. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

19 (a) JUL 12 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10th 1947, at 12 55 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-20 1946 to 7-10 1947. and that I last saw h in alive on 7-9- 1946.

Immediate cause of death: Dehydration — Duration: 2 mo

Due to: Bronchogenic Carcinoma — 2 yr. 8 mo 21 days +

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Emmert M. D.
Address Medical Arts Bldg. Date signed

VS 150

G53386 Gordy

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G53386

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2506 Hermosa Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2506 Hermosa Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sallie B. Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Thomas F. Lewis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 13, 1861

8. AGE: Years	Months	Days	If less than one day
85	10	17	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Josiah F. Parks
13. Birthplace Md.

MOTHER
14. Maiden Name Priscilla Hopkins
15. Birthplace Md.

16 (a) Informant Mrs. Guy J. Leister
(b) Address 2506 Hermosa Avenue 14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/13/47 (month) (day) (year)
(c) Cemetery or crematory Lewis Family Cem.
Location Hooperville, Maryland

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) JUL 12 1947 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11, 1947, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1945 to July 11 1947 and that I last saw h alive on July 9 1947

Immediate cause of death Chronic myocarditis — Duration 5 years

Due to

Due to

Other Conditions Chronic Bronchitis — 12 years
Senile Dementia — 10 years
(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: no

of autopsy: no

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide? no
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury none

23. Signature L. L. Gordy M.D.
Address 5706 Harford Rd Date signed 7/14/47

G53387

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 567

Registered No. G53387

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton + Wilkins Avenues
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8 N. Hilton St. 21
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert L. Carter

3 (b) If veteran, name war: none
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Ella M Carter
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 3, 1894
8. AGE: Years 53 | Months 1 | Days 8 | If less than one day hr. min.
9. Birthplace Va. (Town, county, and state)
10. Usual Occupation machinist
11. Industry or business Consolidated Ices Co.
FATHER 12. Name Samuel J Carter
13. Birthplace Va.
MOTHER 14. Maiden Name Nannie A Shepard
15. Birthplace Va.
16 (a) Informant Mrs. Ella M. Carter
(b) Address 8 N. Hilton St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/14/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto. Md.
19 (a) JUL 12 1947 (Date rec'd by registrar) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/11 1947 at 1:28 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/29 1947 to 7/11 1947. and that I last saw h[illegible] alive on 7/11 1947.

Immediate cause of death: Respiratory failure

Due to

Due to

Other Conditions: Cerebral tumor (Meningioma?)
(Include pregnancy within 3 months of death)

Date of operation 7/7/47

Major findings of operation: Cerebral tumor right temporal

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature J C Englewood
Address St. Agnes Hosp. Date signed 7/14/47

G53388

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131 B

Registered No. G53388

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Underline the cause to which death should be charged statistically. Please write in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 39 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1538 N. Monroe St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ridgley L. Keyes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	

6 (b) Name of husband or wife Alice Keyes

6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) 8-14-07

8. AGE: Years	Months	Days	If less than one day
39	11	25	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Luther Keyes

13. Birthplace

MOTHER 14. Maiden Name Jennie Bryant

15. Birthplace

16 (a) Informant Mrs. Alice Keyes

(b) Address 1538 N. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 13, 1947 (month) (day) (year)

(c) Cemetery or crematory St. Luke's

Location Reisterstown, Md.

18 (a) Funeral director Chas. Jay A. Hudson

(b) Address 1631 Druid Hill Ave.

19 JUL 12 1947 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-9-47 5:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-3-47 to 7-9-1947. and that I last saw h[illegible] alive on 7-9-47.

Immediate cause of death: Pulmonary Edema — Duration
Cardiac Failure
Due to: Chronic nephritis — 3 yrs.
Due to
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Pyelonephritis, acute, suppurative, bilateral

of autopsy: Chronic, small kidney

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. A. Sisson M. D.

Address Johns Hopkins Hosp. Date signed 10 Jul 47

VS 150

G53389

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D

G53389
Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LAFAYETTE AND JOHN ST.
(c) Hospital or institution:
WOMAN'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 67 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. LINDEN AVE AND LAKE DR.
RIVIERA APTS (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME FLORENCE A. LAUCHHEIMER

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife SYLVAN H LAUCHHEIMER
6 (c) If alive, give age 99 years

7. Birth date of deceased (mo., day, yr.) OCT. 12, 1879

8. AGE: Years	Months	Days	If less than one day
67	8	29	....hr. ....min.

9. Birthplace BALTIMORE — MARYLAND
(Town, county, and state)
10. Usual Occupation HW
11. Industry or business HOME

FATHER
12. Name DAVID AMBACH
13. Birthplace GERMANY

MOTHER
14. Maiden Name FANNIE B. BURGUNDER
15. Birthplace BALTIMORE - MARYLAND

16 (a) Informant SYLVAN H. LAUCHHEIMER
(b) Address RIVIERA APTS

17 (a) Burial (b) Date thereof 7/13/47.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto. Hebrew
Location Balto. Md.

18 (a) Funeral director Alpha Embalming Co
(b) Address 1902 Eutaw Place

19 JUL 12 1947 (b) Huntington Williams M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 July 19 47, at 7:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 21 JUNE 1947, to 11 July 19 47, and that I last saw her alive on 10 July 19 47.

Immediate cause of death	Duration
RESPIRATORY FAILURE	
Due to CEREBRO VASCULAR ACCIDENT	15 Days
Due to HYPERTENSIVE CARDIOVASCULAR DISEASE	2 6 YRS
Other Conditions ARTERIO SCLEROSIS. GASTRO INTESTINAL BLEEDING	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dan'l B. Ayer Jr M. D.
Address Woman's Hosp. Date signed July 47

VS 150

G53390

CERTIFICATE CORRECTED 1-10-51

BALTIMORE CITY HEALTH DEPARTMENT

STINNUT CERTIFICATE OF DEATH 12 B

Registered No. G53390

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 711 Druid Hill Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 711 Druid Hill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond Virgil Stinnett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Ellen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/19/

8. AGE: Years 33 | Months 9 | Days 20 | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name George Stinnett
13. Birthplace Md

MOTHER 14. Maiden Name Lillian Jackson
15. Birthplace

16 (a) Informant Ellen Stinnett
(b) Address 711 Druid Hill Ave

17 (a) Burial (b) Date thereof July 12/47
(Burial, cremation, or removal) (Month) (day) (year)

(c) Cemetery or crematory Mt Calvary
Location A A Co Md

18 (a) Funeral director Isaac R Brown Son
(b) Address 1056 W Montgomery St

19 (a) Filed [illegible] 19 47 Huntington Williams, M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/9/ 1947, at 11 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1/ 1947 to 7/9/ 1947 and that I last saw him alive on 7/7/ 1947

Immediate cause of death Pulmonary T-B — Duration 1 yr.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Matthew Gaines M.D.
Address 450 W Biddle St Date signed 7/10/47

G53391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G53391

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3409 Cedardale Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3409 Cedardale Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES HENRY TINKER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1882

8. AGE: Years	Months	Days	If less than one day
65	5	24	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired Accountant
11. Industry or business P. R. R.

FATHER
12. Name Matthew Tinker
13. Birthplace England

MOTHER
14. Maiden Name Mary A. Pott
15 Birthplace England

16 (a) Informant Miss Jane Tinker
(b) Address 3409 Cedardale Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7.14.47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 JUL 10 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10, 1947 at 10:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from JUN 18 1947 to JULY 10 1947 and that I last saw HIM alive on JULY 10 1947

Immediate cause of death: Coronary Thrombosis — Duration: 6/10/47
Due to: Arteriosclerosis — Duration: ?
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert O'Sutent M. D.
Address 1503 Park Heights Ave Date signed 7/10/47

G53392

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G53392
Registered No.

CERTIFICATE OF DEATH 95c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ky. (b) County
(c) City or town South Williamson (If outside city or town limits, write RURAL and give town)
(d) Street No. Box 713 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Basil Anderson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Nancy.
6 (c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) 2-21-00

8. AGE: Years	Months	Days	If less than one day
47 48	4	18	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Rail Road.
11. Industry or business

FATHER 12. Name James Aldus Anderson
13. Birthplace Va

MOTHER 14. Maiden Name Rose Helen Deal
15. Birthplace Va

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 14 47 (Month) (day) (year)
(c) Cemetery or crematory Fairview Cemet
Location Hallamson W Va

18 (a) Funeral director John O Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) JUL 9 1947 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1947, at 10.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1947 to July 11 1947, and that I last saw him alive on July 11 1947.

Immediate cause of death	Duration
Uremia	10 da
Due to Acute glomerulonephritis	2 mo
Due to	
Other Conditions Cardiac decompensation	3 hrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert E. Mason M. D.
Address Johns Hopkins Hosp Date signed 12 July 47

Huntington Williamson W Va

130

G53393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

78 B

Registered No. G53393

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Monument & Rutland St
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 5 da.
(e) Length of stay in Baltimore (yrs., mos., or days): 6 Mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: paltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 1700 E. Pratt Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: BABY - DENNIS NEVIL STEPHENS

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 28, 1946

8. AGE: Years	Months	Days	If less than one day
1	4	15	hr. min.

9. Birthplace: Detroit, Michigan
(Town, county, and state)
10. Usual Occupation: none
11. Industry or business

FATHER
12. Name: Everette STephens
13. Birthplace: Kentucky

MOTHER
14. Maiden Name: Winifred Kaiser
15. Birthplace: Tenn.

16 (a) Informant: Everette Stephens
(b) Address: 1700 E. Pratt Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/15/47 (month) (day) (year)
(c) Cemetery or crematory
Location: Prestonburg, Kentucky

18 (a) Funeral director: HENRY SANDER & SONS, INC
(b) Address: NORTH AVE. & BROADWAY

19 (a) (Date received by registrar) (b) Registrar

JUL 19 1947
VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 11 1947, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1947, to July 11 1947 and that I last saw h/m alive on July 11 1947.

Immediate cause of death: Respiratory failure
Due to: Lead Poisoning & Lead Encephalitis?
Due to:
Other Conditions: Hypochromic Anemia
(Include pregnancy within 3 months of death)

Duration
over

Date of operation:
Major findings of operation:
of autopsy: County nurse.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Asher Friedman M. D.
Address: Sinai Hosp. Date signed 7/11/47

X

G53394

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G53394 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 813 Bonaparte Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 813 Bonaparte Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret E Lyons

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: -S-

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 80 | Months - | Days - | If less than one day hr. min.

9. Birthplace Hollidaysburg, Pa (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Michael Lyons
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Early
15. Birthplace —

16 (a) Informant Mrs. C. L. Farmerie
(b) Address 5896 Bartlett St. Pitts. Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-15-47 (month) (day) (year)
(c) Cemetery or crematory Calvery Cem
Location Pitts. Pa.

18 (a) Funeral director Wiedefeld & Son
(b) Address Greenmount & 22nd St.

19 (a) (Date rec'd by registrar) (b) Registrar

JUL 13 1947

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12th 1947, at 10:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1947 to July 12 1947, and that I last saw her alive on July 11 1947

Immediate cause of death: Coronary Thrombosis — Duration: 1 hr

Due to: Mellus Regurgitation Emphysema Arteriosclerosis & Hypertension — 3 days

Due to: Chronic Interstitial Nephritis — 3 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J F A Stevens M. D.

Address 2878 Harford Rd Date signed 7-12-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

G53395

CERTIFICATE OF DEATH

G53395 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Sinai Hospital
(b) Street address Monument & Rutland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town) 4329 Reisterstown Road
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William A Sigler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Doris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1907

8. AGE: Years 40 | Months 4 | Days 4 | If less than one day hr. min.

9. Birthplace Montreal Canada (Town, county, and state)

10. Usual Occupation
11. Industry or business Plumbing Supplies

FATHER 12. Name Harris Sigler
13. Birthplace Russia

MOTHER 14. Maiden Name Sarah Becker
15. Birthplace Russia

16 (a) Informant Doris Sigler
(b) Address 4329 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 13, 1947 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (Date received by registrar) 7-18-1947 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12, 1947, at 10:17 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-8 1947 to 7-12 1947, and that I last saw h. alive on 7-12 1947

	Duration
Immediate cause of death Pneumonia	
Due to Pulmonary TBC	?
Due to Multiple Sclerosis	5 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: TBC, Pneumonia, M. Sclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Maurice A Perelli M.D.
Address Sinai Hospital Date signed 7/12/47

X

G53396 Lena

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G53396

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2306 E. Fairmount av, 6
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 51 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2306 E. Fairmount
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Lena Keiser

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband ~~or wife~~ Abraham Keiser
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) 1871

8. AGE: Years	Months	Days	If less than one day
76			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation At home

11. Industry or business —

FATHER
12. Name Joseph Konumdarden
13. Birthplace Poland

MOTHER
14. Maiden Name Mildred
15. Birthplace Poland

16 (a) Informant Sidney Keiser
(b) Address 2410 Edwards Road

17 (a) Burial (b) Date thereof July 13 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel
Location Forman Hill Rd.

18 (a) Funeral director Sol Furman & Bro
(b) Address 1124-26 W North ave

19 (a) (b)
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1947, at 12.25 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1947 to July 10 1947, and that I last saw h[illegible] alive on July 10 1947.

Immediate cause of death	Duration
Coronary occlusion	
Myocarditis	
Due to Arterio sclerosis	
Due to	
Other Conditions Pruritus Vulvae and ani	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Kader M. D.
Address 2306 Eutaw Pl Date signed 7-12-47

Huntington Williams, MD

G53397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

G53397 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Seville Apartments (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Lena Hartz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Moses Hartz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) ? 1873

8. AGE: Years	Months	Days	If less than one day
74	—	—	hr. min.

9. Birthplace Lithuania (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name Louis Sugar
13. Birthplace Russia

MOTHER
14. Maiden Name Stellan Leah ?
15. Birthplace Russia

16 (a) Informant Mr. Louis Hartz
(b) Address 933 Brooks Lane, City 17

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 13/47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship, Levin
Location 3600 E Baltimore St

18 (a) Funeral director Sol Levinson & Bro
(b) Address 1124-26 W North ave

19 (a) (Date rec'd by registrar) (b) Registrar

JUL 13 1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-11 1947, at 4:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-9 1947, to 7-11 1947 and that I last saw her alive on. 7-11 1947.

Immediate cause of death ~~Hypertension~~ ~~Confluent Fever~~ disease cerebral hemorrhage
Due to Hypertensive cardio-vascular disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature A. Wade [illegible] M. D.
Address Union Memorial Hosp. Date signed 7-[illegible]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53398 — BALTIMORE CITY HEALTH DEPARTMENT — G53398

CERTIFICATE OF DEATH V 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2617 E Fairmount Ave
(c) Hospital or institution: V
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2617 E Fairmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Grasmick

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married~~, widowed, or divorced.
Male	White	Widow

6 (b) Name of husband or wife Theresa S.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9 1874

8. AGE: Years	Months	Days	If less than one day
73		1	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name George W Grasmick
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Dorothea Lamfus
15. Birthplace Baltimore Md

16 (a) Informant George W. Grasmick
(b) Address 2617 E Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 14 47 (month) (day) (year)
(c) Cemetery or crematory Pastorwood
Location Taylor Ave

18 (a) Funeral director John C Moran
(b) Address 3000 E Baltimore St

19a) 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1947 at 1 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 23 1946 to July 10 1947, and that I last saw h[illegible] alive on Feb 11 1947.

Immediate cause of death	Duration
acute Cardiac Failure	
Due to Coronary artery occlusion.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. a. Flanigan M.
Address 3503 Fait Ave Date signed 7-11-47 M. D.

G53399

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G53399 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mercy Hospt
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3939 Fellemount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dr John G. Fowler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 23 1898

8. AGE: Years 49 | Months 9 | Days 17 | If less than one day hr. min. (48)

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation

11. Industry or business Dentist

FATHER
12. Name John L Fowler
13. Birthplace Md.

MOTHER
14. Maiden Name Rachel Mattingley
15. Birthplace Md

16 (a) Informant Anna E. Fowler
(b) Address 3939 Fellemount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem
Location Pikesville

18 (a) Funeral director John C Moran
(b) Address 3000 E Baltimore St

19 (a) Date rec'd by registrar (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/5/47 19 to 7/10/ 19 47 and that I last saw h alive on 7/10/ 19 47.

Immediate cause of death	Duration
Acute Cardiac Dilatation	1 day
Due to	
Due to	
Other Conditions Coronary Thrombosis	5 days

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr John G. Hamrade

Address 16 E Chase Street Date signed M. D. 7/12/47

3 1947

V S 150

G53400 BALTIMORE CITY HEALTH DEPARTMENT G53400

CERTIFICATE OF DEATH 131a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) XXXXXX

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 821 E 41st St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. James Henry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 3 1867

8. AGE: Years 79 | Months 8 | Days 7 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name John L Henry ?
13. Birthplace Md

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 14 1947 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Govans

18 (a) Funeral director John C Moran
(b) Address 3000 E Baltimore St

19 (a) 1947 Huntington Williams M.D. (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1947, at 8:47 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 4 1947 to July 10 1947, and that I last saw him alive on July 10 1947.

Immediate cause of death	Duration
Cardiac Failure	
Due to Arteriosclerotic Heart Disease	
Due to	
Other Conditions Arteriosclerotic nephritis + bronchitis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Arteriosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Gordon Moran Jr. M.D.
Address Maryland General Hosp. M. D. Date signed July 10 1947

G53401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G53401 Registered No. 131a

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Rd
(c) Hospital or institution Harford & Govan Leisure Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 113 E 25th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Minnie L Malone

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, ~~married, widowed~~, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 7 1877

8. AGE: Years 69 | Months 8 | Days 4 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Owen Malone
13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Callisham
15. Birthplace England

16 (a) Informant Marie E Brown
(b) Address 113 E 25th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 15/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Old Frederick Road

18 (a) Funeral director John C Moran
(b) Address 3600 E Baltimore St

19 (a) (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1920 1920 to July 11 1947.
and that I last saw h alive on July 9 1947

Immediate cause of death Cardiac dilatation — Duration 24 hours

Due to Cardio-vascular-renal disease — Duration 10 yrs

Due to — Duration —

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E N Hayward M. D.
Address 115 E Eager St Date signed 7/12-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53402

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G53402 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2476 Shirley Ave
(c) Hospital or Institution: Mt Carmel Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2705 Ulman Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fannie Mutchnik

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Marcus

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Harel

13. Birthplace Russia

MOTHER 14. Maiden Name Miriam

15. Birthplace Russia

16 (a) Informant Harry Mutchnik

(b) Address 2902 Chelsea Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-13-47 (month) (day) (year)

(c) Cemetery or crematory Hebrew Mt. Carmel

Location

18 (a) Funeral director Jack Lewis Inc

(b) Address 1409 E Balto St

JUL 13 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-12-1947, at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1946 to July 12 1947. and that I last saw h[er] alive on July 12 1947.

Immediate cause of death: Pulmonary edema — Duration: 3 or 4 days

Due to: Cardiac failure — 4 months

Due to: Arteriosclerosis — early

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Reuben A. Kolmen M.D.

Address 3700 York Houghton Date signed July 13 1947 M.D.

X

G53403

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G53403 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette St.
(c) Hospital or institution: Bon Secours Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 10
(If outside city or town limits, write RURAL and give town)
(d) Street No. Notre Dame of Md. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Sister Mary Ellen Russell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/15/06

8. AGE: Years	Months	Days	If less than one day
40	7	27	hr. min.

9. Birthplace Roxbury, Mass.
(Town, county, and state)

10. Usual Occupation Religious

11. Industry or business

FATHER
12. Name Edward Russell
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Sheehan
15. Birthplace Ireland

16 (a) Informant Sr. Mary Tomasine
(b) Address Notre Dame of Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 15/47 (month) (day) (year)
(c) Cemetery or crematory Notre Dame of Md
Location Charles St

18 (a) Funeral director Geo. M. Fenwick Son
(b) Address 811 N. Wolfe St

19 (a) Date 1947 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1947, at 10 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw her alive on July 12 1947.

Immediate cause of death Pitbude
Terminal bronchopneumonia

Due to Long standing
Bronchial asthma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul J. Mannion M. D.
Address Bon Secours Hosp. Date signed 7/12/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53404

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G53404

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 900 N. Linwood Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph A. Guthrie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Margaret Guthrie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 4 1888

8. AGE: Years	Months	Days	If less than one day
58	11	11/30	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Criminal Court

FATHER
12. Name Joseph Guthrie
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Mary J. Bodeo
15. Birthplace Baltimore

16 (a) Informant Margaret Guthrie
(b) Address 900 N. Linwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 15 (month) / 47 (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Geo M. Fritz & Son
(b) Address 811 N Wolfe St

19 (a) [illegible] (b) [illegible] Williams Registrar

JUL 13 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1947, at 1:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1947, to July 11 1947, and that I last saw h.e alive on July 11 1947.

Immediate cause of death	Duration
Subdural Hematoma	
Due to Trauma	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation July 10 1947
Major findings of operation: Subdural Hematoma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 7/1
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 7/11/47 Time 1:15 AM
(c) Where did injury occur? 900 N. Linwood Ave Baltimore Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No (Specify type of place)
(e) Means of injury Fell & Hood
23. Signature William A. Schnitker M. D.
Address Mercy Hospital Date signed July 11 1947

X

G53405

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G53405 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Sinai Hospital
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland
(c) Hospital or institution: Sinai Hospital 37
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 37 S. Lloyd St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Bugatch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Esther

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 78 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Samuel
13. Birthplace Russia

MOTHER
14. Maiden Name Elsie
15. Birthplace Russia

16 (a) Informant Wife Person
(b) Address

17 (a) Burial (b) Date thereof 7-13-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bradale
Location Pikesville Rd & Hamilton Ave

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Baltimore St.

19 (a) (b) Registrar

JUL 19 1947 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-12-47 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 9 19 47 to July 11 19 47 and that I last saw him alive on July 11 19 47.

	Duration
Immediate cause of death Bronchopneumonia	2 days
Due to Cardiac failure	1 wk
Due to Arteriosclerosis	5 yrs
Other Conditions Paralytic ileus	4 days

(Include pregnancy within 3 months of death)

Date of operation Early 1944
Major findings of operation: CA of Sigmoid
of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R.K. Cohnberg M. D.
Address Sinai Hosp. Date signed 7/11/47

X

G53406

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 129

G53406
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2805 Benefit St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Nassal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-14-1900

8. AGE: Years 47 | Months 3 | Days 27. | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER
12. Name Frank Nassal
13. Birthplace Germany

MOTHER
14. Maiden Name Theresa Wahlfram
15. Birthplace Md.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 15-1947 (month) (day) (year)
(c) Cemetery or crematory Trinity Cemetery
Location Balto., Md.

18 (a) Funeral director Maurice G. Byers
(b) Address 1600 W. North Ave

19 (a) (Date received by registrar) Hampton Hollingsworth, Registrar

JUL 13 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1947, at 8.01 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 11 July 1947, to 11 July 1947, and that I last saw h[illegible] alive on 11 July 1947.

Immediate cause of death: Generalized peritonitis — Duration: 7

Due to: Unknown

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation 11 July 47

Major findings of operation: Sub phrenic abscesses & gen. peritonitis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James R. Carroll M.D.
Address The Johns Hopkins Hosp. Date signed 11 July 47

G53407

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH V 122a

Registered No. G53407

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Martin St. and Linden Ave.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Westminster Route 4
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Edward Little

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	W. Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1880

8. AGE: Years	Months	Days	If less than one day
67		29	hr. min.

9. Birthplace Carroll Co. Maryland
(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name Jacob H Little
13. Birthplace Md.

MOTHER
14. Maiden Name Anna Margaret Duff.
15. Birthplace Carroll Co.

16 (a) Informant Harry Little
(b) Address Mt. Winsdon

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 16-47 (month) (day) (year)
(c) Cemetery or crematory Krider's
Location Carroll Co.

18 (a) Funeral director H. Benhard Son
(b) Address Westminster Md

JUL 14 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-13 1947 at 4:08 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-12 1947 to 7-13 1947, and that I last saw h.im alive on 7-13 1947.

Immediate cause of death Anaemia and respiratory failure due to ruptured postpartum ectopic

Due to and shock following operation for reduction of

Due to massive stenosis gallstones kinnies and uplifting of

Other Conditions intestine and abdomen

(Include pregnancy within 3 months of death)

Date of operation 7-12-47

Major findings of operation: Massive complete ingrowth dirt kinnie

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carlton Benshield M. D.
Address M.g. Md. Date signed 7-13-47

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53408

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 47c

Registered No. G53408

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town York
(If outside city or town limits, write RURAL and give town)
(d) Street No. 561 N. Jackson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William E. Reigart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elsie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-11-83

8. AGE: Years 63 | Months 8 7 | Days 2 | If less than one day hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Millwright

11. Industry or business

FATHER 12. Name Wm. Reigart

13. Birthplace Pa.

MOTHER 14. Maiden Name Emmeline Sechrist

15. Birthplace Pa

16 (a) Informant: Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7-13-47 (month) (day) (year)

(c) Cemetery or crematory York Pa

Location York Pa

18 (a) Funeral director Wm. E. Cook Inc

(b) Address 1217 St. Paul St.

19 (a) [illegible] 14 1947 Washington Williamsport Md

(Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1947 at 8:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 21 1947 to July 13 1947, and that I last saw him alive on July 13 1947.

Immediate cause of death: Uremia

Due to: Bronchopneumonia

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: Bronchopneumonia

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.

Address [illegible] Hospital Date signed 7-13-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53409

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G53409

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 272 Mosher St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Habighurst

3 (b) If veteran name war: W

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife George C

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 19 1885

8. AGE: Years 61 | Months 9 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name August A Decker

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Emma M Norris

15. Birthplace Md

16 (a) Informant August A Habighurst

(b) Address 272 Mosher St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/16/47 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Baltimore Md

18 (a) Funeral director Wilhelm & Son Inc

(b) Address 1617 Pont St

19 JUL 14 1947 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1947, at 7:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947 to July 13 1947 and that I last saw h~~e~~R alive on July 13, 1947.

Immediate cause of death Coronary Thrombosis — Duration

Due to Arteriosclerosis

Due to Diabetes Mellitus

Other Conditions Bilateral mid-Thigh Amputation
(Include pregnancy within 3 months of death)

Date of operation 3-29-47, 5-23-47

Major findings of operation: Diabetic gangrene of Right Leg - Diabetic gangrene Left Leg

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John A. Hightower M. D.

Address University Hospital Date signed 7-13-47

G53410 LAMB

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH V 53

G53410 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford Co.
(c) City or town Darlington
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Alexander Lamb

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Annie Lamb

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) 12-1-70

8. AGE: Years 76 | Months 7 | Days 13 | If less than one day — hr. — min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John T. Lamb

13. Birthplace Md.

MOTHER 14. Maiden Name Mary Harper

15. Birthplace Md.

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 16 1947 (month, day) (year)

(c) Cemetery or crematory Darlington

Location Harford Co., Md.

18 (a) Funeral director H. L. Baile

(b) Address Darlington, Md.

19 (a) JUL 14 1947 (Date received by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-13-1947, at 6.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-8-47 to 7-13 1947 and that I last saw him alive on 7-13 1947.

Immediate cause of death	Duration
Cardiac - respiratory failure	12 hrs
Due to Bilateral lower lobe pneumonia	72 hrs
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation July 10 - 1947

Major findings of operation: Skin Cancer of hand

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Milton Edgerton

Address Johns Hopkins Date signed July 14, 1947 M.D.

VS 150

G53411

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G53411

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1014 N. Payson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1014 N. Payson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Francis Pickering

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/10/47, 19, at M

4. Sex: Male
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Fannie Theresa nee Wright

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1870

8. AGE: Years 77 | Months 1 | Days 25 | If less than one day hr. min.

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 19 47 to July 10 19 47 and that I last saw him alive on July 10 19 47

Immediate cause of death: Chronic valvular heart

Due to: disease

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

9. Birthplace: Balto., Md. (Town, county, and state)

10. Usual Occupation: Seafood Dealer

11. Industry or business: Own Business

FATHER
12. Name: George Pickering
13. Birthplace: Md.

MOTHER
14. Maiden Name: Ursilla Tapman
15. Birthplace: Md.

16 (a) Informant: Mrs. Fannie Pickering
(b) Address: 1014 N. Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 14 47 (month) (day) (year)
(c) Cemetery or crematory: London Pk.
Location: 3801 Frederick Rd.

18 (a) Funeral director: Harry H. Wintzle
(b) Address: 4101 Edmondson Ave.

19 JUL 14 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Ernest F. Lahm M.D.
Address: 1736 Park Ave Date signed 7/10/47 M. D.

VS 150

G53112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 178a

Registered No. G53112

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1327 N. Luzerne Ave
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1327 N. Luzerne Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Salvatore (MIRANGO) MIRANDO

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Eleanor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-25-1895

8. AGE: Years	Months	Days	If less than one day
52	3	17	hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation Fruit Merchant

11. Industry or business Self

FATHER
12. Name Alphonso Miranda
13. Birthplace Italy

MOTHER
14. Maiden Name Fortuna Ventre
15. Birthplace Italy

16 (a) Informant Eleanor Miranda
(b) Address 1327 N. Luzerne Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/16/47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Gorsuch Hill Rd.

18 (a) Funeral director Lilly & Zeiler Co.
(b) Address 403 S. Wolfe St

19 JUL 14 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1947 at 7:25 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, probably suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carbon monoxide poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-12-47 at 7 A M.
(b) Where did injury occur? 1327 N. Luzerne Ave
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Jet on gas heater turned on

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 7/12/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53413

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G53413 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 S. Collington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 514 S. Collington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles Weissner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Elizabeth Livingston
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 1, 1901

8. AGE: Years	Months	Days	If less than one day
45 46	11	11	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Labor
11. Industry or business

FATHER 12. Name Joseph Weissner
13. Birthplace Ger.

MOTHER 14. Maiden Name Carrie Brown
15. Birthplace Baltimore

16 (a) Informant Michael Horn
(b) Address 4211 La Salle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/16/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belgian Road

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. Wolfe Street

19. JUL 14 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1947 at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 14 1947 to July 12 1947 and that I last saw him alive on July 12 1947

Immediate cause of death: Acute Coronary Insufficiency — Due to Acute Bronchio-pneumonia

Duration
2 days
1 wk.

Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Chas. F. Douglas M. D.
Address 700 E. Fayette Date signed 7/14/47

G53414 G53414

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G53414

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3308 N. Calvert St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 66 years.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3308 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Hattie Claibaugh Roberts.
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 17, 1881.

8. AGE: Years	Months	Days	If less than one day
66	4	24	hr. min.

9. Birthplace Baltimore, Maryland.
(Town, county, and state)
10. Usual Occupation House work
11. Industry or business —

FATHER
12. Name George Roberts
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Emma Carmack.
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Jennie Slaughter
(b) Address 3308 N. Calvert St.

17 (a) Burial (b) Date thereof July 14/47
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Cemetery or crematory Green Mt. Cem.
Location Greenmount ave. & North

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1405 Eastern Place

19 (a) JUL 11 1947 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1947, at 8.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1946. to July 11 1947. and that I last saw her alive on July 9 1947.

Immediate cause of death	Duration
Chronic Myocarditis	?
Due to Arterio-sclerosis	?
Due to Senility	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature O. Walter Spurrier M.D.
Address 3603 Edmondson Ave Date signed 7/11/47 M. D.

G53415

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓14

G53415 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1313 E. Lombard
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie Banks

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-26-24

8. AGE: Years 22 | Months 9 | Days 16 | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER 12. Name Paul Banks

13. Birthplace Va

MOTHER 14. Maiden Name Annabelle Smith

15. Birthplace Va

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 7/16/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location Balto. County, Md.

18 (a) Funeral director Joseph D. Locke

(b) Address 1304 N. Central Ave.

19 (a) JUL 14 1947 Huntington Williams, M.D. Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1947 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 22 1947 to July 12 1947 and that I last saw h[illegible] alive on July 12 1947.

	Duration
Immediate cause of death: Meningitis	
Due to: Tuberculosis	4 mo
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address Johns Hopkins Hosp Date signed 7/15/47

VS 150

G53416

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G53416

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2402 Druid Hill Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2402 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Garfield Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-12-5145

4. Sex M | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Hilda Wilson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-27-95

8. AGE: Years 51 | Months 9 | Days 15 | If less than one day hr. min.

9. Birthplace Monkton, Md.
(Town, county, and state)

10. Usual Occupation Baggage Clerk

11. Industry or business B&O Rail Road

FATHER
12. Name John Wilson
13. Birthplace Monkton, Md

MOTHER
14. Maiden Name Louise Ward
15. Birthplace Hartford Co.

16 (a) Informant Hilda Wilson
(b) Address 2402 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-15-47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Arbutus, Md.

18 (a) Funeral director Charles L. Law
(b) Address 807 Mad. Ave.

19 JUL 14 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-12 1947 at 12:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1946 to July 12 1947 and that I last saw him alive on July 12 1947.

Immediate cause of death	Duration
Cardiac & Respiratory Failure	
Due to Carcinomatosis	
Ca - Rectum & Prostate	2 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos. E. Brown M. D.
Address 2840 Madison Ave Date signed 7-18-47

VS 130

653417

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓166

Registered No. 653417

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1013 Whatcoat Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel W. Stevenson (Stevens) Jr.

3 (b) If veteran, name war: WW #2
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-20-27

8. AGE: Years 19 | Months 9 | Days 21 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Samuel Stevens
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mary Brown
15. Birthplace Md.

16 (a) Informant Mrs. Mary Stevens
(b) Address 1013 Whatcoat St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-15-47 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Fredrick Ave.

18 (a) Funeral director Charles L. Lawn
(b) Address 802 Madison Ave

19 (a) JUL 14 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11, 1947, at 10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑; undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Bullet - wound of lungs

Due to

Other Conditions

(include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7/10/47 at 10 P.M.
(b) Where did injury occur? In front of 24 N. Gilmor St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearms

23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 7/11/47

G53418

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13/a

G53418
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1113 Woodyear St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willie Borum (Bowen)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: (Death) Priscilla

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) 9-14-90

8. AGE: Years 56 | Months 9 | Days 26 | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Fertilizer Factory

11. Industry or business

FATHER
12. Name William Borum
13. Birthplace Va

MOTHER
14. Maiden Name Priscilla Young
15. Birthplace Va

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-14-47 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location md

18 (a) Funeral director George H. Nelson
(b) Address 3923 Portsmouth St

JUL 14 1947 (Date rec'd by registrar) (b) Huntington Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1947 at 9.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from July-2 1947, to July-10 1947, and that I last saw him alive on July-10 1947.

Immediate cause of death: Cardiac Failure — Duration:
Due to Uremia
Due to Arteriosclerotic Nephritis — 6 mos.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. T. Gisson
Address Johns Hopkins Hosp. Date signed 11 Jul 47 M. D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53419 Birth Certificate No. 70714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 160 C

Registered No. G53419

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Streets
(c) Hospital or institution: The Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-da.
(e) Length of stay in Baltimore (yrs., mos., or days) 1-da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Long Point, Pasadena (If outside city or town limits, write RURAL and give town)
(d) Street No. —
(e) Citizen of foreign country? No (If rural give location) (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Suzanne Stierhoff

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	white	single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 7-12-47

8. AGE: Years	Months	Days	If less than one day
0	0	1	16 hr. 10 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Walter G. Stierhoff
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Rosemary Houck
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. R. V. Houck
(b) Address 530 Lorraine Ave., City

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7 14 47 (month) (day) (year)
(c) Cemetery or crematory GLENHAVEN
Location ANNE ARUNDEL Co.

18 (a) Funeral director A. R. SLADE
(b) Address 4907 YORK RD.

19 (a) (Date rec'd by registrar) Huntington Williams, M.D.

JUL 14 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1947 at 2:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 12 1947 to July 13 1947 and that I last saw h[illegible] alive on July 10 1947.

Immediate cause of death	Duration
Respiratory Failure	
Due to CNS Pathology	16 hr. 10 min.
Due to Birth (Premature Birth wt 2-14 (3' wks) gestation	
Other Conditions Hydramnios & Abruptio-placenta of Uterus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury

23. Signature E R Chambers M. D.
Address Union Memorial Hosp. Date signed 7-13-47
33-Calvert St., Baltimore, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 138

Registered No. G53420

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 825 N. Brice St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 825 N. Brice St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** FLORENCE MAY JENNINGS

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Charles Joseph Jennings
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 6, 1879

8. AGE: Years 68 | Months 4 | Days 6 | If less than one day ... hr. ... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Henry Rethmann
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Mary Plummer
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mr. Norman Jennings
(b) Address: 2344 Lauretta Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/15/47 (month) (day) (year)
(c) Cemetery or crematory: Balto. National Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) JUL 14 1947 (Date received by registrar) (b) Registrar: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12, 1947, at 3:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1947 to July 12 1947, and that I last saw her alive on July 8 47

Immediate cause of death	Duration
Respiratory failure	
Due to Pulmonary tuberculosis	
Due to	
Other Conditions Diabetes mellitus Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. Sborofsky M.D.
Address 601 N. Monroe St Date signed 7/14/47 M. D.

G53421

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G53421

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 415 Edgewood St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 0 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 415 Edgewood St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine May Galloway

3 (b) If veteran, name war –
3 (c) Social Security Account No. –

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Wm. Galloway
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1875

8. AGE: Years 71 | Months 7 | Days 11 | If less than one day hr. min.

9. Birthplace Balt.
(Town, county, and state)

10. Usual Occupation Home maker

11. Industry or business

FATHER: 12. Name Albert Thomas
13. Birthplace Md. (Jefferson)

MOTHER: 14. Maiden Name Sarah A. Dieben
15. Birthplace Va. (Leesburg)

16 (a) Informant Mrs. Walcott Anders
(b) Address 415 Edgewood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/14/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 JUL 14 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1947 at 7a, M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1947 to July 11 1947 and that I last saw h-r alive on July 5 1947.

Immediate cause of death	Duration
Coronary occlusion	
Due to	
Due to	
Other Conditions Myocarditis	6 Mos

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John A Evans M. D.
Address 402 N 40 Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G53122

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution West Balto Genl. Hospl

(d) Length of stay in hospital or inst. (yrs., mos., or days) Dom
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write R.F.D. and give town)
(d) Street No. 5702 Park Heights Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Edward Allers

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28, 1891

8. AGE: Years 56 | Months 5 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Mgr.

11. Industry or business Kriel Packing Co.

FATHER
12. Name B. Frank Allers
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Florence K. Conway
15. Birthplace Balto., Md.

16 (a) Informant Mr. B. Frank Allers
(b) Address 5702 Park Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/15/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUL 14 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11th 1947, at 6:45 P.M.

21. I certify that I took charge of the remains described above, held an Ext Ed Insp thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Helpluck M.D. (Medical Examiner.)
Date signed July 13 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53423

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164c

Registered No. G53423

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 620 E. 21st Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cora E. Brothers

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Married

6 (b) Name of husband or wife Herschel Brothers
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Dec. 16, 1895

8. AGE: Years	Months	Days	If less than one day
51	6	28	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Clarence J. Burrier
13. Birthplace Maryland

MOTHER
14. Maiden Name Estella B. Cross
15. Birthplace Maryland

16 (a) Informant Clarence H. Brothers
(b) Address 620 E. 31st Street

17 (a) Burial (b) Date thereof 7-16-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Braglynn Avenue

18 (a) Funeral director Edmondson & Dyson
(b) Address 3617 Edmondson Ave

19 (a) JUL 14 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-13-1947, at 5.55 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of brain

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-13-47 at 5:30 P. M.
(b) Where did injury occur? 620 E. 21st St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
Means of injury Firearms 32 Cal.

23. Signature George H. Merrill M.D.
Medical Examiner.
Date signed 7/14/47

VS 151

C53424

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C53424

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Lunar
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 78 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3333 Gwynns Falls Parkway (If rural give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) FULL NAME NAVIASKY, JENNIE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	Widow

6 (b) Name of husband or wife Nathan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
77			hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Fishel
13. Birthplace Russia

MOTHER
14. Maiden Name Leah
15. Birthplace Russia

16 (a) Informant Louis Naviasky
(b) Address 3603 Springdale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-16-47 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh
Location Dolfield Blvd Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 1409 E Balto St

19 JUL 14 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1947, at 2:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-13 1947, to 7-13 1947, and that I last saw h[illegible] alive on 7-13 1947.

Immediate cause of death	Duration
Coronary Sclerosis, Myocardial Fibrosis	
Left sided Cardiac failure.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Allan Y. Wolinsky M. D.
Address Lunar Hosp Date signed 7-13-47

G53425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BC# 983518

157E

Registered No. G53425

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Women's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) ½ day
(e) Length of stay in Baltimore (yrs., mos., or days) ½ day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1857 W. North Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Weidner

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		½	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Julius Edward Weidner
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Cliff Pearl
15. Birthplace Baltimore Md

16 (a) Informant Mother
(b) Address 1857 W North Ave

17 (a) Burial (b) Date thereof 7-14-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loredale
Location Philadelphia Rd & Hamilton Ave
18 (a) Funeral director Jack Lewis Inc
(b) Address 1420 E Balto St
19 (a) JUL 14 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1947 at 6 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/12/47 19 to 7/13/47 19, and that I last saw him alive on 7/13/47 19

Immediate cause of death anoxia

Due to congenital cardiac malformation

Due to

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. L. Summerlin M. D.
Address Women's Hospital Date signed 7/13/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

G53426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. G53426

PLEASE WRITE PLAINLY, WITH UNPADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE 24
(If outside city or town limits, write RURAL and give town)
(d) Street No. 530 S. ELRINE ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William "Bill" PANAGIOTOU

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	single.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1931

8. AGE: Years	Months	Days	If less than one day
16 16	0	6	hr. min.

9. Birthplace GREECE (Town, county, and state)

10. Usual Occupation ~~Student~~ School boy

11. Industry or business

FATHER
12. Name GEORGE PANAGIOTOU
13. Birthplace GREECE

MOTHER
14. Maiden Name STELLA MAKAKIS
15. Birthplace GREECE

16 (a) Informant father
(b) Address 330 S Elrino St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-14-47 (month) (day) (year)
(c) Cemetery or crematory Cemetery Greek
Location Windsor Mill Rd

18 (a) Funeral director Lambros Fun Home
(b) Address 440 E. North ave

19 (a) JUL 14 1947 (Date received by registrar) Twistington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1947 at 6:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947 to July 12 1947 and that I last saw him alive on July 12 1947.

Immediate cause of death Acute lymphatic leukemia.

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry B. Scott M. D.
Address Mercy Hospital Date signed 7/12/47

VS 150

G53427

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G53427

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Levindale Home
(b) Street address Belevedere & Greenspring Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 17 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2632 Park Heights Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard Kretchmar

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Late Gussie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
72			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Moris Kretchman
13. Birthplace Russia

MOTHER
14. Maiden Name Miriam Pominsky
15. Birthplace Russia

16 (a) Informant Mrs Ethel Friedman
(b) Address 2632 Park Heights Terrace

17 (a) Burial (b) Date thereof July 14, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) JUL 14 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1947, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-1 1947 to 7-13 1947, and that I last saw h[illegible] alive on 7-13 1947.

Immediate cause of death	Duration
Bronchopneumonia	
Generalized arteriosclerosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Edmund Levin
Address Levindale Date signed 7/13/47

VS 150

G53428

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. G53428

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Monument Sts.
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 wks.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 wks.

2. USUAL RESIDENCE OF DECEASED:
(a) ~~XXX~~ FRANCE (b) ~~XXXX~~ Dep't of SEINE
(b) City or town Vanves
(If outside city or town limits, write RURAL and give town)
(d) Street No. 9 Rue Solferino
(If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country FRANCE

3 (a) FULL NAME Nicole Petey (NICOLE PETEY)

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-11-27

8. AGE: Years 20 | Months 5 | Days 1 | If less than one day: hr. min.

9. Birthplace France (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Marcel Petey
13. Birthplace France

MOTHER
14. Maiden Name Madeline Ranno
15. Birthplace France

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/14/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

19 JUL 14 1947 (Date rec'd by registrar) (Signature) Registrar for Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1947 at 11:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 26 1947 to July 12 1947 and that I last saw her alive on July 12 1947.

Immediate cause of death: Pulmonary Infarction — Duration:

Due to: Tetralogy of Fallot

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation 28 June 1947

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard D. Bush M.D.
Address JHH Date signed 12 July 47

VS 150

G53429

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

Registered No. G53429

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1607 E. Lanvale Street
(c) Hospital or institution:
8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
6 City or town Baltimore
(if outside city or town limits, write RURAL and give town)
(d) Street No. 1607 E. Lanvale Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JANE (SABILLA) HOOS

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John Adam Hoos
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1857

8. AGE: Years 89 | Months 8 | Days 8 | If less than one day hr. min.

9. Birthplace Penna.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Ehrhart
13. Birthplace Pa.

MOTHER
14. Maiden Name Margaret Schnell
15. Birthplace Pa.

16 (a) Informant Mr. Elmer M. Hoos
(b) Address 807 N. Belnord Avenue

17 (a) Burial (b) Date thereof 7/14/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mount Carmel Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) JUL 14 1947 Huntington Williams, M.D.
(Date received by registrar) (b) Address

VS 150

MEDICAL CERTIFICATION AM

20. DATE OF DEATH July 11 1947, at 4.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1947 to July 1947, and that I last saw her alive on 10 July 1947.

Immediate cause of death	Duration
Cerebro-vascular Accident - multiple	1 Day +
Due to Arteriosclerosis	4 wks
Due to Senility	10 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Roy M. Zimmerman, M.D.
Address 2858 Harford Rd Date signed 11 June 47

G53430

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G53430 Registered No. 93E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Ambassador Apts. 17
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Ambassador Apts.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Marion M. Abrahams

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 8, 1859

8. AGE: Years	Months	Days	If less than one day
87	9	4	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Woodward Abrahams
13. Birthplace Cecil County, Md.

MOTHER
14. Maiden Name Margaret E. Littig
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Soper
(b) Address 102 W. 39th St.

17 (a) Burial (b) Date thereof 7/14/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1000 Eutaw Place
Huntington Williams, M.D.

19 (a) (b) Registrar

JUL 14 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 13 1947 to July 12 1947, and that I last saw her alive on July 11 1947.

Immediate cause of death	Duration
Bronchiectasis	
Due to Old age	
Due to old age	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature John A. Evans M. D.
Address 102 W. 39th St. Date signed

X

C53131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C53131

THORMINO

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1402 Caroline St.

(c) Hospital or institution St Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore (Emery) (If outside city or town limits, write RURAL and give town)

(d) Street No. 347 Stallworth Ave #21 (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Mr John Taormino

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/10/1890

8. AGE: Years 57 Months 6 Days 26 If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Contractor

11. Industry or business

FATHER 12. Name Luigi Taormino

13. Birthplace Italy

MOTHER 14. Maiden Name Unknown

15. Birthplace Italy

16 (a) Informant Sam Taormino

(b) Address 347 Stallworth Rd. Ems

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/16/47 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart

Location German Hill Rd.

18 (a) Funeral director John G. Connelly

(b) Address 418 Eastern Ave. Balto

19 (Filed) JUL 14 1947 (Date received by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1947 at 1.25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 3 1947 to July 13 1947 and that I last saw him alive on July 13 1947.

Immediate cause of death	Duration
Cardiac Decompensation	
Due to Hypertensive Cardiovascular disease yrs	
Due to Congestive failure	
Other Conditions Benign prostatic hypertrophy	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cardiac dilatation, Arterio Sclerosis of liver, kidneys

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Harry P. Porter M.D.

Address St. Joseph's Hosp Date signed 7/13/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53432 BALTIMORE CITY HEALTH DEPARTMENT ✓ G53432

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 20 S. Carey St
(c) Hospital or institution:
19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 20 S. Carey St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Daniel J. Farrell

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 22. 1868

8. AGE: Years 78 | Months 9 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Patrol
11. Industry or business B & O. R.R.

FATHER
12. Name Jeremiah Farrell
13. Birthplace Ireland

MOTHER
14. Maiden Name Winifred Garvey
15. Birthplace Ireland

16 (a) Informant Winifred C. Small
(b) Address 20 S. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 15-1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto Md

18 (a) Funeral director Robt C. B. M. Walton
(b) Address Pratt & Stricker St

19 (a) (Date rec'd by registrar) (b) Registrar

JUL 14 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1947, at 3 40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1947 to July 11 1947, and that I last saw him alive on July 11 1947.

Immediate cause of death: Cerebral hemorrhage with oedema — Duration 5 days
Due to: Hypertensive Arteriosclerotic — about 15 yrs
Due to: Cardio-vascular disease
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John F. Carbaden, M. D.
Address 24 W. Fullton Ave Date signed 7/12/47

X

G53433

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5 1 B

Registered No. G53433

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2315 E Preston Pl
(c) Hospital or institution:
8-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2315 E Preston Pl (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Wiegand

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-05-8039

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Minnie Wiegand

6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) July-13-1877

8. AGE: Years 70 | Months - | Days - | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business Bartlett + Hayward

FATHER 12. Name Unknown
13. Birthplace "

MOTHER 14. Maiden Name "
15. Birthplace "

16 (a) Informant Minnie Wiegand
(b) Address 2315 E Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-16-47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave

18 (a) Funeral director John C Miller Inc
(b) Address 2435 E Oliver St

19 (a) 7-14 1947 (Date received by registrar) (b) Huntington Williamsport, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-13 1947, at 11:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/19 1946 to 7/13 1947, and that I last saw him alive on 7/13 1947.

Immediate cause of death	Duration
Bilateral Bronchopneumonia	1
Due to Carcinoma prostate with metastases	1yr?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Karl Grossman M. D.
Address 1212 N. Patterson Park Ave Date signed 7/14/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1823

Registered No. G53434

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1624 E. Pratt Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NICHOLAS SANTILLA or SUNDAE

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
No	217-07-3491	Male	White	Widowed

6 (b) Name of husband or wife late Jennie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Monte Aderisio, Italy
(Town, county, and state)
10. Usual Occupation Pipe layer
11. Industry or business

FATHER
12. Name Pietro Santilla
13. Birthplace Italy

MOTHER
14. Maiden Name Rosaria Piccirilli
15. Birthplace Italy

16 (a) Informant Domenico Santilla (Brother)
(b) Address 6117 Wine St. Philadelphia, Pa.

17 (a) Burial (b) Date thereof July 15 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road, Balto., Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 524 W. Mosley St.

19 (a) JUL 14 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11, 1947, at 12 20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to falling earth

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7/11/47 at 1115 A. M. 25/2
(b) Where did injury occur? 3200 blk. Clarinda Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public Street While at work? Yes
(d) Means of injury Cave-In (Digging trench for a sewer main)

23. Signature Howard J. Claire, M.D.
Medical Examiner.
Date signed 7--11-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C53435

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

182 B

Registered No. C53435

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 215 S. Exeter Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH RUSSO

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-01-2463

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lena Russo
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18, 1885

8. AGE: Years	Months	Days	If less than one day
62	3	23 24	hr. min.

9. Birthplace Roseto degli Abruzzi, Italy (Town, county, and state)
10. Usual Occupation Pipe Layer
11. Industry or business

FATHER
12. Name Massimo Russo
13. Birthplace Italy

MOTHER
14. Maiden Name Loreta Di Leonardo
15. Birthplace Italy

16 (a) Informant Lena Russo (wife)
(b) Address 215 S. Exeter Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 15, 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road, Balto., Md.

18 (a) Funeral director Pranulli Della Rose
(b) Address 542 N. Hanover St

19 (a) JUL 14 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11, 1947, at 3:30P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to falling earth

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 25/a
(a) Date of injury 11:15 a.m. 7-11-47
(b) Where did injury occur? 3200 blk. Clarinda Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public street While at work? Yes
(d) Means of injury Cave-In (Digging trench for a sewer main)

23. Signature Howard J. Madden M.D. Medical Examiner.
Date signed 7-12-47

C53436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. C53436

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 225 S. High St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 27 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 225 S. High St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALFIO or Alfred Marano

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband~~ wife Angela Marano

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 27 1895

8. AGE: Years 52 | Months 3 | Days 15 | If less than one day hr. min.

9. Birthplace Riposto Catania Italy
(Town, county, and state)

10. Usual Occupation Grocery Store owner

11. Industry or business

FATHER
12. Name Filippo Marano
13. Birthplace Italy

MOTHER
14. Maiden Name Angela Bonaventura
15. Birthplace Italy

16 (a) Informant Angela Marano (Wife)
(b) Address 225 S. High St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 16/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) JUL 17 1947 (Date rec'd by registrar) (b) Huntingtown Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 July 1947, at 12.25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1946 to 12 July 1947 and that I last saw h[im] alive on 12 July 1947.

Immediate cause of death: Carcinoma of Liver — Duration: 12 yrs.

Due to

Due to

Other Conditions: Diabetes Mellitus, Cardiac Decompensation
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. H. Kammer, Jr. D.
Address 501 Sheridan Ave. Date signed 12 July 47

VS 150

12 U 12

G53437

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH √ 139c

Registered No. G53437

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert Stuet.
(c) Hospital or institution: Mercy Hospital Calvert & St. Baltimore maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED: anne Arundel
(a) State Md. (b) County Brooklyn
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Furnace Br. Road. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME AMANDA BURKHARDT

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Frank J. Burkhardt
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) 8/5/97

8. AGE: Years	Months	Days	If less than one day
49	11	25	hr. min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

MOTHER / FATHER
12. Name William G. Goodrich
13. Birthplace Washington D.C.
14. Maiden Name Elizabeth Hamilton
15. Birthplace Maryland

16 (a) Informant Frank J. Burkhardt
(b) Address Brooklyn Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 17-47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Brooklyn
Location Gor. Ritchie Highway

18 (a) Funeral director Milton Schilling
(b) Address 2914 Hanover St - 25

19 JUL 14 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 19 47 at 1205 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1947 to July 13 1947 and that I last saw h[illegible] alive on July 13 1947.

Immediate cause of death Cardiac failure — Duration: under 1 day

Due to Exhaustion and senera — Duration: 1 day

Due to diabetes — Duration: 2 diabetes

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation July
Major findings of operation: Prolapse of Vagina
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. M. Finnigan M.D.
Address Mercy Hospital Date signed July 13 1947

C53438

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH V164a

Registered No. C53438

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 807 Hollins Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David C BROUGH

3 (b) If veteran, name war: WORLD WAR II
3 (c) Social Security Account No. 226-14-1356

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: SINGLE
6 (b) Name of husband or wife: —
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) JUNE-4-1922
8. AGE: Years 25 | Months 1 | Days 7 | If less than one day ____ hr. ____ min.
9. Birthplace HOPEWELL VA. (Town, county, and state)
10. Usual Occupation HELPER.
11. Industry or business

FATHER
12. Name Jos. D. Brough.
13. Birthplace Va.

MOTHER
14. Maiden Name Elonore. Jones
15. Birthplace Va.

16. (a) Informant Jos D Brough.
(b) Address 837 S Paca St
17. (a) ~~Interment~~ Removal (b) Date thereof 7/14/47 (month) (day) (year)
(c) Cemetery or crematory Blandford Cem.
Location RICHMOND Va
18 (a) Funeral director Bernard C Harley
(b) Address 1000 S Paca St.
19 (a) JUL 14 1947 (Secretary-Registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11, 1947, at 10.30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Asphyxiation by hanging
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-11-47 at about 10 p. M.
(b) Where did injury occur? 807 Hollins St. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Hanging by rope-attached to gas pipe

23. Signature Geo. L. Merrill M.D.
Medical Examiner.
Date signed 7/12/47

VS 151

G53439

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G53439

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 628 N. Lee Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD JACKSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years 58 | Months | Days | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation L

11. Industry or business

FATHER 12. Name James Jackson
13. Birthplace Va

MOTHER 14. Maiden Name Ella V Smith
15. Birthplace Va

16 (a) Informant Hattie Carpenter
(b) Address 628 W Lee St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 15 47 (month) (day) (year)
(c) Cemetery or crematory Bath National
Location Baltimore Md

18 (a) Funeral director Isaiah L Brown Son
(b) Address 108 W Montgomery Street

19 JUL 14 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10, 19 47 at 1.05 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Occlusion
Hypertrophy & Acute Dilatation Heart
Due to Senile Arteriosclerosis

Other Conditions Nephrosclerosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mendis M.D.
Medical Examiner.
Date signed 7-11-47

95c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53440

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G53440

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1329 Cambria Street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) -
(e) Length of stay in Baltimore (yrs., mos., or days) -

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town 1329 Cambria Street (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Arthur Henry Taylor

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: 218 09 5680

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Oliva J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 3, 1884

8. AGE: Years 62 | Months 7 | Days 11 | If less than one day ..... hr. ..... min. 10

9. Birthplace: Baltimore (Town, county, and state)
10. Usual Occupation: Carpenter
11. Industry or business

FATHER
12. Name: Thomas A. Taylor
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: Laura I. Ray
15. Birthplace: Baltimore

16 (a) Informant: Arthur W. Taylor
(b) Address: 208 Annapolis Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 16 (month) (day) (year)
(c) Cemetery or crematory: Cemetery
Location: Cedar Hill

18 (a) Funeral director: Wm. Cook, Inc.
(b) Address: 17 St. Paul Street

19 (a) JUL 14 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 19 47 at 9:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/12 19 47 to 7/15 1947, and that I last saw [illegible] alive on 7/15/47 19 .

Immediate cause of death: Cerebral Hemorrhage — Duration:
Due to: Hypertension
Due to: Cardiovascular disease
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: [signature] M. D.
Address 203 [illegible] Date signed 7/16/47

G53441

Dr Hyde 1100 E North Ave

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G53441

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1922 Oak Hill Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1922 Oak Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lydia Ella Gaston

3 (b) If veteran, name war: W
3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edward A

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1861

8. AGE: Years 86 | Months 2 | Days 2 | If less than one day: hr. min.

9. Birthplace Snarrsville Ga (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Benjamin Hutmer
13. Birthplace Snarrsville Ga

MOTHER
14. Maiden Name Lydia LeFevre
15. Birthplace Snarrsville Ga

16 (a) Informant Edward A Gaston
(b) Address 1922 Oak Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/16/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Spesutie Hd

18 (a) Funeral director Wilson & Son
(b) Address 1217 E Fort Ave

19 (a) JUL 14 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1947, at 11 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1947 to July 12 1947, and that I last saw her alive on July 12 1947

Immediate cause of death: Cerebral thrombosis arteriosclerosis

Due to: Colon Carcinoma Degeneration

Due to:

Other Conditions:

(include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration
9

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Karon Hyde M.D.

Address 1100 E North Ave Date signed 7/14/47

G53442

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

87E

G53442

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1216 Bayard St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ~~Balto~~
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1216 Bayard St
(If rural give location)
(e) Citizen of foreign country? V (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Johnson
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1932

8. AGE: Years	Months	Days	If less than one day
14	11	12	hr. min.

9. Birthplace Balto, Md
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Clarence Johnson
13. Birthplace Balto, Md

MOTHER
14. Maiden Name Eunice Wallace
15. Birthplace Anne Arundle Co, Md

16 (a) Informant Mrs Eunice Wallace Johnson
(b) Address 1216 Bayard St

17 (a) Burial (b) Date thereof 7-18-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Ass
Location Baltimore Maryland

18 (a) Funeral director Mrs T. R. Williams
(b) Address 322 N. Schroeder St

19 (a) (b) Huntingdon Williams, Md

JUL 14 1947
VS Tbo

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 19 47, at 8:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 15 19 47, to July 12 19 47, and that I last saw h alive on July 20 19 47.

Immediate cause of death Malnutrition — Duration 1 months

Due to Paralysis of muscles of deglutition — 1 month

Due to Cerebral Diplegia congenital — since age of 3

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature John P. Ulrich Jr
Address 122 W Madison St Date signed 7/12/47

X

G53443

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1942

Registered No. G53443

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 810 W. Franklin St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 810 W. Franklin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Clegg Houston.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: James

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 20, 1892.

8. AGE: Years	Months	Days	If less than one day
54 5	9 6	21	hr. min.

9. Birthplace Greensboro N. C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas Sewell.
13. Birthplace Greensboro N.C.

MOTHER
14. Maiden Name Henrietta ?
15. Birthplace Greensboro N.C.

16 (a) Informant Mrs. Alberta Simpson.
(b) Address 1818 Riggs Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-14-1942 (month) (day) (year)
(c) Cemetery or crematory Arlington Memorial
Location

18 (a) Funeral director Mrs K. A. Williams
(b) Address 322 N. Schroeder St

19 (a) (State or city registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-11 1942, at 1:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-10 1942 to 7-11 1942 and that I last saw h alive on 7-11 1942.

Immediate cause of death	Duration
(a) Coronary Thrombosis	2
Due to (b) Not determined	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hugh J. Wardlaw M. D.
Address 851 Cathedral Date signed 7-17-42

G53444

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 92B

Registered No. G53444

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 925 DeSota Road
(c) Hospital or institution: **********
(d) Length of stay in hospital or inst. (yrs., mos., or days) ********
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 925 DeSota Road (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME BLANCHE V. HITCHENS

3 (b) If veteran, name war **********
3 (c) Social Security Account No. **********

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife James J. Hitchens
6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1880

8. AGE: Years	Months	Days	If less than one day
67	5	10	********** hr. min.

9. Birthplace St. Marys County, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Benj. Goddard
13. Birthplace St. Marys County, Md.

MOTHER
14. Maiden Name Maria K. Evans
15. Birthplace St. Marys County Md.

16 (a) Informant Mr. Lewis I. Owens
(b) Address 925 DeSota Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 15/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore County Md.

18 (a) Funeral director F.B. WIPPERT & SON
(b) Address 1300 Eutaw Place....c.17

19 (a) JUL 14 1947 (Date rec'd by registrar) Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 th. 1947, 2:15A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/15 1947 to 7/12 1947, and that I last saw h. er alive on 6/12 1947

Immediate cause of death	Duration
Mitral Stenosis	5 yrs
Coronary Thrombosis	4 mos
Due to	
Due to Pulmonary Congestion	1 mo
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas A Parker M. D.
Address Baltimore & Smallwood Sts. July 14

G53445

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G53445

170c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2010 Greenmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank E. Brown

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-05-3616

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Grace E. Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 26, 1894

8. AGE: Years 52 | Months 10 | Days 13/14 | If less than one day hr. min.

9. Birthplace Balto, Md (Town, county, and state)

10. Usual Occupation Painter Union # 1

11. Industry or business

FATHER
12. Name Allen F. Brown
13. Birthplace Balto, Md.

MOTHER
14. Maiden Name Rebecca M. Sweetman
15. Birthplace Balto, Md.

16 (a) Informant Mrs Grace E. Brown
(b) Address 2010 Greenmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-16-47 (month) (day) (year)
(c) Cemetery or crematory Maryland Park
Location Balto

18 (a) Funeral director Leonard J. Luck
(b) Address 5305 Harford Road.

19 (a) JUL 14 1947 rec'd by reg. (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11, 1947 at 11.25 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Crushing head
Fractured ribs

Due to

Other Conditions Multiple fractures, lacerations, bruised brain.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 1614
(a) Date of injury 7-11-47 at 11 P.M.
(b) Where did injury occur? Monroe St & Riggs ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian Struck by auto

23. Signature Howard J. Mahoney M.D. Medical Examiner.
Date signed 7-12-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53446

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 46 B

G53446

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert St.

(c) Hospital or institution: Mercy Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 38 days

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balto

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 7701 Harford Rd. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Joseph M. Adams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Mary A. Adams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 5 1870

8. AGE: Years	Months	Days	If less than one day
76	11	9	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation (Electrician) Stationary

11. Industry or business Mercy Hospital Engineer

FATHER 12. Name John Adams

13. Birthplace Balto Md.

MOTHER 14. Maiden Name ? MARY ANNA HART

15. Birthplace Md.

16 (a) Informant wife

(b) Address 7701 Harford Rd.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7-17-47 (month) (day) (year)

(c) Cemetery or crematory HOLY REDEEMER

Location BALTIMORE, MD.

18 (a) Funeral director Howard J. Rueb

(b) Address 5305 Harford Rd

19 JUL 14 1947 (Date rec'd by registrar) Huntington Williams M.D. (Filing Deputy)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 14 19 47 at 3 37 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 7 1947 to July 14 1947 and that I last saw him alive on July 7 1947.

Immediate cause of death Debilitation

Due to Gastric Carcinoma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation June 19

Major findings of operation: Gastric Ca

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. M. Finnegan M. D.

Address Mercy Hospital Date signed July 14

G53447

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

G53447 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St.
(c) Hospital or institution: Home for the Aged Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Magdelena Gustaitiene

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife No knowledge

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25, 1878

8. AGE: Years 69 | Months 3 | Days 19 | If less than one day hr. min.

9. Birthplace Lithuania (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William Radamich

FATHER 13. Birthplace Lithuania

MOTHER 14. Maiden Name Anna Cibelle

MOTHER 15. Birthplace Lithuania

16 (a) Informant Little Lithuanian Boy

(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 15, 1947 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director Peter Tiedfeld

(b) Address 900 East Biddle St.

19 (a) (Date rec'd by registrar) (b) Registrar

JUL 14 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1947, at 8:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947 to July 13 1947, and that I last saw [illegible] alive on July 8 1947.

Immediate cause of death

Duration

Coronary Thrombosis

Due to Anemia 6 Mos

Due to

Other Conditions Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jacob Frolow M. D.

Address 1823 N Market St. Date signed 7/14/47

X

G53148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G53148

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... correct age is especially important. Physicians: please write the... the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 12 days
(e) Length of stay in Baltimore (yrs., mos., or days): 12 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: Montgomery
(c) City or town: Bethesda
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 4608 Windsor Lane
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: Oro R. Holaday

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife: Joseph Holaday
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 20, 1878

8. AGE:	Years	Months	Days	If less than one day
	68	9	24	hr. min.

9. Birthplace: ? Oregon (Town, county, and state)
10. Usual Occupation: None
11. Industry or business

FATHER
12. Name: John R. Overholtzer
13. Birthplace: Pa.

MOTHER
14. Maiden Name: Mary Barr
15. Birthplace: Pa.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof July 14/47 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet Cem.
Location: Baltimore, Md.

18 (a) Funeral director: Wm. R. Plumphrey
(b) Address: 1505 Wilson Ave.

(a) JUL 15 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 14 19 47, at 12:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 2 19 47 to July 14 1947, and that I last saw h er alive on July 14 19 47.

Immediate cause of death	Duration
Carcinoma of rectum with metastasis to vagina and bilateral diffuse metastasis to	
Due to the lungs.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature: Stuart W. Sessoms M. D.
Address: U.S. Marine Hospital Date signed: 7-14-47

X

G53449

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 56E

Registered No. G53449

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W Va (b) County
(c) City or town Odd
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dremia Lavane Wickline

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-15-46.

8. AGE: Years	Months	Days	If less than one day
	7	29	hr. min.

9. Birthplace W Va (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER 12. Name Williams Wickline
13. Birthplace Va.

MOTHER 14. Maiden Name Gredie Coffman
15. Birthplace W Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried Removed (b) Date thereof July 14 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Cole City West Va.

18 (a) Funeral director Harry H. Kitzke
(b) Address 4101 Columbus Ave

19 JUL 15 1947 (b) Huntington Williamson W Va
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1947 at 11 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 11 1947 to July 14 1947 and that I last saw her alive on July 14 1947.

Immediate cause of death Cardiac failure.

Due to Post-Operative, post-anesthesia Shock

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Barton Childs M.D.
Address Johns Hopkins Hosp. Date signed 7-14-47

Approved W. E. Kilpatrick

G53450

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G53450
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 629 Franklintown Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 29yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2743 Kuhn Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Johanna Love Fargo

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John Fargo
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 27 1865

8. AGE: Years 81 | Months 10 | Days 16 | If less than one day hr. min.

9. Birthplace Ft Marys Co Md (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Richard Love
13. Birthplace Md (Charles Co)

MOTHER
14. Maiden Name Jane L Thompson
15. Birthplace Md (St Marys County)

16 (a) Informant Francis J Love
(b) Address 2743 Kuhn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/14/47 (month) (day) (year)
(c) Cemetery or crematory Loudenslager
Location Baltimore Md

18 (a) Funeral director Wilson Colvin
(b) Address 1217 E Pratt St

(a) Date received JUL 15 1947 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1947, at 9:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1926, to July 12 1947, and that I last saw her alive on July 12 1947.

Immediate cause of death: Cerebral Hemmorhage — Duration 1 mo 28a
Due to: Hypertension — 7
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chester Riland. M. D.
Address 2532 Edmondson Ave Date signed 7-14-47

G53451

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 837

Registered No. G53451

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1330 Sargeant St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1330 Sargeant St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY JANE CONNOLLY ALLERS

3 (b) If veteran, name war	3 (c) Social Security Account No.
no.	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Wm. A. Allers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25, 1866

8. AGE: Years	Months	Days	If less than one day
80	11	26	7 hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Connolly
13. Birthplace Ireland

MOTHER
14. Maiden Name -
15. Birthplace

16 (a) Informant Mr. William L. Allers
(b) Address 706 E. 35th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/15/47 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Cem.
Location Howard Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JUL 15 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11, 1947, at 8:45PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947, to July 11 1947 and that I last saw h[illegible] alive on July 11, 1947.

Immediate cause of death: Cent Cardiac Failure — Duration

Due to Arteriosclerosis

Due to

Other Conditions Hemiplegia

(Include pregnancy within 3 months of death)

Date of operation -

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide -
(b) Date of occurrence - at M
(c) Where did injury occur? - (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jones J. Stokes M. D.
Address 876 W[illegible] Date signed 7/13/47

97

653152

BALTIMORE CITY HEALTH DEPARTMENT (X 937)

CERTIFICATE OF DEATH

Registered No. G53152

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) Se From

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 821 Frederick Road (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) **FULL NAME** John J. Ammanhauser

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1-2-1895

8. AGE: Years 52 | Months 6 | Days 11 | If less than one day ..... hr. ..... min.

9. Birthplace Catonsville - Maryland (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Retired

FATHER
12. Name Jacob Ammanhauser
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Pfeffer
15. Birthplace Maryland

16 (a) Informant Charles Ammanhauser
(b) Address 821 Frederick Ave - Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-15-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director Edw. L. MacNabb
(b) Address Catonsville-21, Md.

19 (a) JUL 15 1947 (Date rec'd by registrar) Huntington Station, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 July 1947, at 4:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5 July 1947 to 13 July 1947 and that I last saw h alive on 13 Jul 1947

Immediate cause of death: Heart Failure — Duration: .....
Due to: Hypertensive Cardio-
Due to: Vascular Disease
Other Conditions .....
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....

23. Signature James C Hamill MD M. D.
Address St Agnes' Hosp Date signed .....

X 13 Jul 47

G53153

BALTIMORE CITY HEALTH DEPARTMENT

BCH D83558 CERTIFICATE OF DEATH V 16/a

G53153

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Fayette and Calhoun Sts.

(c) Hospital or institution: Franklin Square Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da.

(e) Length of stay in Baltimore (yrs., mos., or days) 1 da.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. Fayette and Calhoun Sts. 1943 W. Fayette St. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME David Michael Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white.

6 (a) Single, married, widowed, or divorced: Infant.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1947

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name David Thomas Smith

13. Birthplace Buffalo, New York

MOTHER — 14. Maiden Name Doris Elizabeth

15. Birthplace Baltimore, Md.

16 (a) Informant Doris Smith.

(b) Address 1993 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-15-47 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore

18 (a) Funeral director Geo. A. Farley

(b) Address Fayette [illegible] St.

19 (a) JUL 15 1947 (Date received by registrar) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-12- 1947, at 9:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/12/1947 to 7/12/1947, and that I last saw h alive on 7/12/1947.

Immediate cause of death: Congenital atelectasis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation: 0

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Geo A Macneille

Address Franklin Sq Hosp. Date signed 7/13/47

X

G53454

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G53454 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hampnett Ave.
(c) Hospital or institution: Pineridge Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-4
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6217 Everall Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME AUGUSTA VOGTS

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: widow
6 (b) Name of husband or wife: Charles H. Vogts
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Nov. 17, 1870
8. AGE: Years 76 | Months 7 | Days 26 | If less than one day: hr. min.
9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Benjamin Hardy
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Johanna Krieger
15. Birthplace: Germany

16 (a) Informant: William D. Vogts
(b) Address: St. Louis, Missouri

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: July 1947 (month) (day) (year)
(c) Cemetery or crematory: Parkwood Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS. INC.
(b) Address: Baltimore 13 Md.

JUL 15 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1947 at 11:45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 14 1947 to July 13, 1947, and that I last saw h[illegible] alive on July 13 1947.

	Duration
Immediate cause of death: Cerebral Hemorrhage	4 hours
Due to: Hypertension	2 years
Due to: Arteriosclerosis	2 years
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide?
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Michael J. Dausch M. D.
Address 1 W. Overlea Ave. Date signed 7-14-47

G53455

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G53455

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Raynor & Dudley

(c) Hospital or institution: Mt Baltimore San Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days): 1 day

(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md (b) County: Balto.

(c) City or town: paltimore (If outside city or town limits, write RURAL and give town)

(d) Street No.: 820 Riverside Drive (If rural give location)

(e) Citizen of foreign country?: (Yes or No)

If yes, name country:

3 (a) FULL NAME: Charles Johnson (CHARLES SEGAR JOHNSON)

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary Stewart

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 11, 1872

8. AGE: Years	Months	Days	If less than one day
75	5	2	hr. min.

9. Birthplace: Richmond, Va. (Town, county, and state)

10. Usual Occupation: Painter

11. Industry or business: Retired 5 yrs.

FATHER

12. Name: William Johnson

13. Birthplace: Va.

MOTHER

14. Maiden Name: Susan Tolar

15. Birthplace: Richmond, Va.

16 (a) Informant: Mr. Wm. Johnson

(b) Address: 219 N. Patterson Park Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/13/47 (month) (day) (year)

(c) Cemetery or crematory: Oak Lawn Cemetery

Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.

(b) Address: NORTH AVE. & BROADWAY

19 JUL 14 1947 Registrar Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 13 July 1947, at 9:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 13 July 1947 to 13 July 1947 and that I last saw h[illegible] alive on 10 July 1947

Immediate cause of death: Coronary Occlusion. Duration:

Failure

Due to: Incarcerated left femoral hernia

Due to:

Other Conditions: Bronchopneumonia

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury:

23. Signature: Lester G. Dalley M. D.

Address: Mt Balt San Hosp Date signed: 7/13/47

122a

G53456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G53456 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6309 Weidner Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6309 Weidner Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: LUTHER FRANK READ

3 (b) If veteran, name war: WO

3 (c) Social Security Account No. 213-14-4845 A

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife: Lydia Matthews

6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) Aug. 6, 1869

8. AGE: Years 77 | Months 11 | Days 5 | If less than one day 30 hr. min.

9. Birthplace Baltimore Co. Md. (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name Oliver Read
13. Birthplace Maryland

MOTHER
14. Maiden Name Frances ?
15. Birthplace Maryland

16 (a) Informant W. L. Smith
(b) Address 334 Broadmore Road - 12

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/15/47 (month) (day) (year)
(c) Cemetery or crematory Friends Burial Grounds
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) Date received by Local Registrar (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1947, at 8.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 15 1939 to July 11 1947, and that I last saw h alive on June 21 1947.

Immediate cause of death: Coronary Occlusion — Duration 6 mo.
Due to: Arteriosclerotic heart disease — 10 yrs.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. J. Chesnut M. D.
Address 6210 York Rd Date signed 7/14/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

053457

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered 053457

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 712 S. Linwood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 72 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 712 S. Linwood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE FRANCIS WINSLOW

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 219-01-5869

4. Sex: M.
5. Color or race: W
6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1. 1873

8. AGE: Years 74 | Months 5 | Days 12 | If less than one day hr. min.

9. Birthplace Cumberland, Md.
(Town, county, and state)

10. Usual Occupation Watchman
11. Industry or business

FATHER
12. Name John F. Winslow
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Catherine Phillip
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Kate Winslow
(b) Address 712 S. Linwood

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/16/47 (month) (day) (year)
(c) Cemetery or crematory Mount Carmel Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) Date received 1947 (b) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13, 1947 9.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 2 1946, to July 13 1947, and that I last saw h. alive on July 12 1947.

Immediate cause of death	Duration
CARCINUMA OF RECTUM	9-2-46
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation:
of autopsy: NONE.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence NONE at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. A. Schimmek M. D.
Address 542 S. Ellwood Date signed 7-14-47

G53458

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

G53458 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital 12-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1710 St. Paul St.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Ireland

3 (a) FULL NAME Samuel Joseph Nolan

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1887

8. AGE: Years	Months	Days	If less than one day
59	11	26	hr. min.

9. Birthplace Dublin, Ireland
(Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business Seafarer

FATHER
12. Name Charles Nolan
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Kennedy
15. Birthplace Ireland

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-16-1947 (month) (day) (year)
(c) Cemetery or crematory ST. MATTHAI
Location O'Donnell St.
18 (a) Funeral director Lilly & Zeiler Inc
(b) Address 403 S. Wolfe St.
19 (a) Date received by registrar JUL 15 1947 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1947, at 2:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 23 1947, to July 10 1947, and that I last saw him alive on July 10 1947.

Immediate cause of death (1) Pneumonia right lower lobe (2) Hemorrhagic pericardial effusion, marked.
Due to (3) Fibrinous pericarditis
Due to (4) Pleural effusion, moderate, bilateral.

Duration	Diage
1= 2 days	
2,3 & 4	
1 wk.	

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 7/14/47

X

C53459

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. C53459

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4508 Sebenly Road

(c) Hospital or institution: Church Home & Hospital 27

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County B

(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 4506 Sebenly Rd.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis P. Bortner LOUIS P. BORTNER

3 (b) If veteran, name war: World War II

3 (c) Social Security Account No. 0

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14, 1898

8. AGE: Years	Months	Days	If less than one day
49	3	0	hr. min.

9. Birthplace Balt. Md.
(Town, county, and state)

10. Usual Occupation Steel handler

11. Industry or business

FATHER
12. Name Barton Tobey
13. Birthplace Balt. Md.

MOTHER
14. Maiden Name Stokes Lake, Mary
15. Birthplace Carroll Co. Md.

16 (a) Informant Brother. Earl Bortner
(b) Address 4508 Sebenly Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 16-1947 (month) (day) (year)
(c) Cemetery or crematory St. Paul's
Location Arcadia, Baltimore Co, Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

JUL 15 1947 (Date received by local registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 19 47 at 9:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1947, to July 14 1947, and that I last saw h. im. alive on July 13 19 47.

Immediate cause of death Carcinoma

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation July 10 1947

Major findings of operation: Inoperable Carcinoma

of autopsy: None obtained

Duration
over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature H. J. Kohlenberger

Address Church Home & Hosp Date signed July 17

X

G53160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G53160

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied—The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4005 Northern Parkway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4005 Northern Parkway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Anthony T Sacrivan

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 214-03-3942

4. Sex: Male

5. Color or race: W

6 (a) ~~Single~~, married, ~~widowed, or~~ divorced

6 (b) Name of husband or wife: Helen J.

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.): June 9 1894

8. AGE: Years 53 | Months 1 | Days 7 | If less than one day ..... hr. ..... min.

9. Birthplace: Balto. (Town, county, and state)

10. Usual Occupation: Stationary

11. Industry or business: Engineer

FATHER
12. Name ? Skrivan
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Dora Kriss
15. Birthplace Czech

16 (a) Informant Helen J. Skrivan
(b) Address 4005 Northern Pky

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 15 47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4300 Belair Rd.

18 (a) Funeral director Mont W. E. Bagley Co.
(b) Address 7110 Belair Rd

JUL 15 1947 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/13/47 19..., at 7:00 P.M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D. (Medical Examiner)
Date signed 7/14/47

G53461

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 B

G53461 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Every correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1533 E. 33rd St.
(c) Hospital or institution:

9-16

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1533 E. 33rd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ARTHUR GORMAN HALL

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	213-09-5914

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Gola L. Hall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1898

8. AGE: Years	Months	Days	If less than one day
48	9	7	hr. min.

9. Birthplace Somerset Co., Md.
(Town, county, and state)
10. Usual Occupation Pres.
11. Industry or business Balto; Fire Co.

FATHER
12. Name Addison S. Hall
13. Birthplace Somerset Co., Md.

MOTHER
14. Maiden Name Bertha M. White
15. Birthplace Somerset Co., Md.

16 (a) Informant Mrs. Gola L. Hall
(b) Address 1533 E. 33rd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/16/47 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 JUL 15 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13, 1947, at 5:00PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1943 to July 13 1947 and that I last saw h[illegible] alive on July 13 1947.

Immediate cause of death	Duration
Pulmonary Tuberculosis	1939
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. W. Jacobsen M. D.
Address 2310 Eutaw Place Date signed 7-14-47

Jacobsen X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 8 3a

Registered No. G53162

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1808 Spence St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1808 Spence St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CARRIE CRESCENTIA BOYD

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: Charles C. Boyd
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 28, 1865

8. AGE: Years	Months	Days	If less than one day
81	10	16	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation -
11. Industry or business

FATHER
12. Name Jacob Gross
13. Birthplace Germany

MOTHER
14. Maiden Name Kate Stieff
15. Birthplace Myerstown, Pa.

16 (a) Informant Mr. C. Clarence Boyd
(b) Address 1808 Spence St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/16/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUL 15 1947 (Registered by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14, 1947, at 12:05 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 10 July 1947 to 14 July 1947 and that I last saw her alive on 13 July 1947.

Immediate cause of death Cerebral Hemorrhage — Duration 4 days
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward J. Miller M.D.
Address 682 Washington Blvd. Date signed July 15, 1947
Baltimore 30 Maryland

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

G53463

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

Registered No. G53163

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4115 Penhurst Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4115 Penhurst Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: LYDIA C. WALLER

3 (b) If veteran, name war: -

3 (c) Social Security Account No. -

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Charles A. Waller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 23, 1880

8. AGE: Years 67 | Months 5 | Days 20 | If less than one day hr. min.

9. Birthplace Butler, Mo. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Slayback
13. Birthplace unknown

MOTHER
14. Maiden Name Martha Cline
15. Birthplace Hillsboro, Ill.

16 (a) Informant Rev. R. I. Berghauser
(b) Address 4115 Penhurst Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/15/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 JUL 15 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1947 at 10:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 29 1946, to July 13 1947, and that I last saw h.e.r alive on July 12 1947.

Immediate cause of death
1) Chronic Myeloid Leukemia

Due to

Due to

Other Conditions - Cystitis - Sclerosis Heart Disease
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy:

Duration
1) 4 years
2) 2 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Earl L. Chambers M. D.
Address 4106 Liberty Hts Date signed July 14-47.

G53464

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G53464

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3408 Powhatan Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3408 Powhatan Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME RENA H. MICHENER

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife: Charles P. Michener
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 16, 1891

8. AGE: Years	Months	Days	If less than one day
56	1	27	hr. min.

9. Birthplace: Balto., Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Jacob Klein
13. Birthplace: Germany

MOTHER
14. Maiden Name: Mary Nichol
15. Birthplace: Germany

16 (a) Informant: Mrs. Amy R. Hackman
(b) Address: 3408 Powhatan Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/16/47 (month) (day) (year)
(c) Cemetery or crematory: Northwood
Location: Phila., Pa.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 JUL 15 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13, 1947, at 10:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 19[illegible], to July 13 1947, and that I last saw her alive on July 12 1947.

Immediate cause of death	Duration
Carcinoma, 4 colon with metastasis to peritoneal glands	
Due to Ruptured appendix (carcinoma)	12/5/44
Due to	
Other Conditions Hypertension	7yo

(Include pregnancy within 3 months of death)

Date of operation 12/6/44 carcinoma of appendix
Major findings of operation: 3rd operation 1/2/45 resection of colon
Carcinoma —
of autopsy: and

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A. Luetscher M. D.
Address 12 E. Eager St. Date signed 7/14/47

X

G53465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓83B

G53165
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3604 Mohawk Ave
(c) Hospital or institution: Anderson's Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 & 4
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5101 Woodside Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. Vernon L. Norwood

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Fannie Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1862

8. AGE: Years: 85 | Months: -- | Days: 7 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: physician
11. Industry or business

FATHER
12. Name: Rufus Norwood
13. Birthplace: Md.

MOTHER
14. Maiden Name: Annie Hyatt
15. Birthplace: Md.

16 (a) Informant: Dr. Vernon H. Norwood
(b) Address: 5101 Woodside Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/16/47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore, Md.

18 (a) Funeral director or person: John O. Mitchell & Sons, Inc
(b) Address: 1900 Eutaw Place

19 JUL 15 1947 (Date rec'd by registrar) (b) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1947 at 10 25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1925 to July 13 1947 and that I last saw him alive on July 13 1947

Immediate cause of death: Cerebral Thrombosis — Duration: 10 days
Due to: arteriosclerosis
Due to:
Other Conditions: myocardial failure — 24 hrs
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Vernon H. Norwood M. D.
Address: Church Home & Hospital Date signed 7/14/47

G53466

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1328

G53466
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 102 N. Bruce St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-2
(e) Length of stay in Baltimore (yrs., mos., or days) 25yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 102 N. Bruce St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM FLETCHER

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/20/1883

8. AGE: Years	Months	Days	If less than one day
63	9	21	hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Mechanic
11. Industry or business Automobile

FATHER
12. Name Wm. Fletcher
13. Birthplace Pa.

MOTHER
14. Maiden Name Annie Wilson
15. Birthplace Pa.

16 (a) Informant Arthur Fletcher(Bro.)
(b) Address 1508 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/15/47 (month) (day) (year)
(c) Cemetery or crematory Western Star Cemetery
Location Balto. County, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave

JUL 15 1947 (a) (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/11/47 19 8:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/7/47 19 to 7/11/47 19, and that I last saw deceased alive on 7/9/47 19

Immediate cause of death: Pulmonary Tuberculosis

Duration
Unknown

Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. F. Somers, M. D.
Address 405 Edmondson Ave Date signed 7/15/47

G53167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G53167

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — D'Ort
(b) Street address 424 Howil Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 - 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 424 Howil Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Rogers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife James

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22 1895

8. AGE: Years	Months	Days	If less than one day
52	4	18	hr. min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Samuel Jones
13. Birthplace Va.

MOTHER
14. Maiden Name Bettie Russell
15. Birthplace Va.

16 (a) Informant Josephine Mayo
(b) Address 424 Howil Terrace

17 (a) Burial (b) Date thereof 7/17/37
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Arbutus Memorial Park

18 (a) Funeral director Mrs. Pott A. Ellison
(b) Address 129 N. Caroline St

19 (a) JUL 15 1937 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/12 1937 at 8:7 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive C.V. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. S. Galbraith M.D.
Medical Examiner.
Date signed 7/13/37

G53168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G53168 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 611 N. Caroline St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 611 N. Caroline St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William J. Cooper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12 1889

8. AGE: Years 57 | Months 11 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER 12. Name William J. Cooper
13. Birthplace Md.

MOTHER 14. Maiden Name Adelaide
15. Birthplace Md.

16 (a) Informant Ida Cooper
(b) Address 1219 N. Bond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/17/47 (month) (day) (year)
(c) Cemetery or crematory Balto. National Cem.
Location

18 (a) Funeral director Mrs. Otto A. Elliott Dept
(b) Address 1129 N. Caroline St.

JUL 15 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12, 1947, at 3:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 5, 1941, to July 12, 1947, and that I last saw him alive on July 12, 1947.

Immediate cause of death: Chronic myocarditis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C.R. Campbell M. D.
Address 718 Dolphin St. Date signed 7-14-47

G53469

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G53469
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address DOA
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 15 years.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits write RURAL and give town)
(d) Street No. 706 N. Gilmore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Priscilla Harris

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1890

8. AGE: Years 57 | Months 4 | Days | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Richard Smith
13. Birthplace Va

MOTHER
14. Maiden Name Katherine Smith
15. Birthplace Va

16 (a) Informant William J. Smith
(b) Address 716 N. Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-17-49 (month) (day) (year)
(c) Cemetery or crematory Lee Hall Va
Location Va

18 (a) Funeral director George G. Nelson
(b) Address 1203 Pennsylvania Ave

19 (a) JUL 15 1947 (Date received by registrar) Huntington, West Virginia

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/14 1947 at 2:45 P.M.

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Feldmeier Medical Examiner. M.D.
Date signed 7/14/47

G53470

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G53470

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1812 Bland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-1
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1812 Bland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jena Shulman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Meyer J

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1890

8. AGE: Years 57 Months Days If less than one day hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name Leon
13. Birthplace Russia

MOTHER
14. Maiden Name Anna
15. Birthplace Russia

16 (a) Informant: Meyer J Shulman
(b) Address: 1812 Bland ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-15-47 (month) (day) (year)
(c) Cemetery or crematory: Shaarei Tfiloh
Location: Windsor Mill Road

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 1429 E Baltimore St

19 Filed July 15 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-14-1947 at 10:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 19 to 7-14 1947 and that I last saw h[illegible] alive on 7/14 1947

Immediate cause of death: Acute Coronary Thrombosis — Duration: 30 Mins

Due to: Embolism Stroke

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: [illegible] M. D.

Address 1904 Reed Street Date signed 7/15/47

VS 150

G53471

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

Registered No. G53471

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1415 St Matthews St
(c) Hospital or institution:
Johns Hopkins Hospital 5+
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 31 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1415 St Matthew Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HERBERT JONES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Evelyn Jones
6 (c) If alive, give age 24 years

7. Birth date of deceased (mo., day, yr.) Mar. 15-22

8. AGE: Years	Months	Days	If less than one day
25	3	27	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Labor.
11. Industry or business

FATHER
12. Name Richard Jones
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Viola Carroll
15. Birthplace Baltimore Md.

16 (a) Informant Viola Jones
(b) Address 20 S. Bond St.

17 (a) Burial (b) Date thereof July 16-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore National Cem.
Location Baltimore Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bloomsbury Ave.

19 (a) Filed [illegible] (b) Registrar Huntington Williams, M.D.
JUL 15 1947

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11, 1947, at 9.45 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Stab-wound of heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-11-47 at about 9 P. M.
(b) Where did injury occur? 1415- Matthew St. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Sharp instrument

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 7-12-47

G53472 BCH 83617

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 160a

Registered No. G53472

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution South Baltimore General Hospital
(d) Length of stay in hospital or inst. (~~years, months~~, or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1121 S. Binney St.
(If rural give location)
(e) Citizen of foreign country? No (~~Yes~~ or No)
If yes, name country

3 (a) **FULL NAME** Baby Girl Beregne

3 (b) If veteran, name war /

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1947

8. AGE: Years	Months	Days	If less than one day
			8 hr. 10 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Newborn

11. Industry or business —

FATHER
12. Name Daniel Beregne
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Catherine Kemmer
15. Birthplace Whitehall, Md.

16 (a) Informant Daniel Beregne
(b) Address 1121 S. Binney St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/16/47 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus Cem.
Location Mt. Carmel Rd.

18 (a) Funeral director Charles J. Dill
(b) Address 1501 E. Fort Ave.

19 (a) JUL 15 1947 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1947, at 9A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-14-1947 to 7-14-1947, and that I last saw her alive on 7-14-1947.

Immediate cause of death	Duration
Intracranial Hemorrhage	—
Due to Labor prolonged	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William S. Miller M. D.
Address S. Balto. Gen. Hosp. Date signed 7-14-47

VS 150

G53473

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G53473

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street
(c) Hospital or institution: City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Sparrows Point Rd
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2107 Sparrows Pt. Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lovell Powell, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13, 1923

8. AGE: Years	Months	Days	If less than one day
24	6	1	hr. min.

9. Birthplace Clarksburg, W. Va.
(Town, county, and state)

10. Usual Occupation Merchant Seaman

11. Industry or business

FATHER
12. Name Isaac L. Powell
13. Birthplace W. Va.

MOTHER
14. Maiden Name Icie M. Herman
15. Birthplace W. Va.

16 (a) Informant Mrs Icie M. Powell
(b) Address 2107 Sparrows Point Rd, Sparrows Point

17 (a) Burial (b) Date thereof July 16, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Frederick Road

18 (a) Funeral director Roland L. Fisher
(b) Address 2947 Dundalk Ave.

19 (a) JUL 15 1947 (b) Huntington Williamsport Md.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1947, 8 10/J M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 24/6
(a) Date of injury 7-4-47 at 6 P. M.
(b) Where did injury occur? Point Breeze
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Drowned Probable Swimming

23. Signature Earl L. Koons M.D.
Medical Examiner.
Date signed

G53474

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G53474 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 805 E. Chase street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10-1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ---
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 805 E. Chase street (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) **FULL NAME** MARY J. KENEALY

3 (b) If veteran, name war ---

3 (c) Social Security Account No.

4. Sex Female

5. Color or race white

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife ---

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 19, 1888

8. AGE: Years 59 | Months 3 | Days 25 | If less than one day 24 hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER
12. Name William J. Kenealy
13. Birthplace New York

MOTHER
14. Maiden Name Delia Kearns
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Anna Kenealy Zick
(b) Address 805 E. Chase street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/18/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas J. Evans Son Inc
(b) Address 118 N. Mt. Royal Ave

19 (a) JUL 15 1947 Washington Williams M.D.
(b) Address

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/14 19 47 at 4:10 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Dec 19 43, to 7/14 19 47, and that I last saw h[illegible] alive on 7/3/47 19

Immediate cause of death Arteriosclerotic Cardiovascular Disease — Duration 5 yrs

Due to

Due to

Other Conditions Cerebral Hemorrhage — 2 weeks.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John C Davis M. D.
Address 211 Med Arts Bldg Date signed 7/15/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53475

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

51B

Registered No. G53475

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Mayland General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 2
(e) Length of stay in Baltimore (yrs., mos., or days) 85 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1813 N. Monroe (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Ireland

3 (a) FULL NAME Thomas Louis Drummey.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-25-60

8. AGE: Years 86 Months 6 Days 17 If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Cornelius Drummey
13. Birthplace Ireland.

MOTHER
14. Maiden Name — London
15. Birthplace Ireland

16 (a) Informant Hospital Records.
(b) Address

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof 7/16/47 (month) (day) (year)
(c) Cemetery or crematory Bethany
Location Balto. City.

18 (a) Funeral director C. Vernon Yeamans
(b) Address 461 Pk. Hgts Ave

19 (a) JUL 15 1947 (Received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/12 1947, at 6:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/11 1947 to 7/12 1947 and that I last saw h. alive on 7/11 1947

Immediate cause of death Ruptured abdominal Aneurysm — Duration

Due to Hypertensive Cardiovascular disease.

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H Mitchell M. D.
Address Md Gen Hosp Date signed 7/12/47

VS 150

30d

G53476

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G53476

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4016 Frankford Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-4
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4016 Frankford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Raymond Stricklen, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-01-3820

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Ella May Stricklen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 13th, 1882

8. AGE: Years	Months	Days	If less than one day
64	7	2	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Accountant
11. Industry or business Read Hayden, Inc.

FATHER
12. Name Wm. Finney Stricklen
13. Birthplace Harford County, Maryland

MOTHER
14. Maiden Name Mary Williams
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Raymond Stricklen
(b) Address 4016 Frankford Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 7/17/47 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Towson, Maryland

18 (a) Funeral director Lasacher Funeral Home
(b) Address 7401 Belair Road

19 (a) JUL 15 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH July 15th 1947, at 3:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 9, 1946 to July 15, 1947, and that I last saw h im alive on July 14, 1947.

	Duration
Immediate cause of death: Coronary occlusion	14 hrs.
Due to: Arteriosclerosis	many yrs.
Due to: Hemiplegia	3 yrs.
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Max R. English M. D.
Address 5713 Belair Rd. Date signed 7-15-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G534777 L# 111828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G534777

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 906 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Frank Monroe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 26-1920

8. AGE: Years	Months	Days	If less than one day
27	2	19	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James monroe
13. Birthplace Va.

MOTHER
14. Maiden Name Eliza Dates
15. Birthplace Va.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof July 15, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Sol Hall, Va.

18 (a) Funeral director Geo. G. Kelson
(b) Address 1303 Eastern Ave

19 JUL 15 1947
(Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15, 1947, at 7:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947 to July 15, 1947 and that I last saw him alive on July 15, 1947

Immediate cause of death	Duration
Respiratory failure	2 da
Due to Pulmonary Tuberculosis	2 mo+
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Bowen Jr. M. D.
Address Baltimore City Hosp. Date signed 7-15-47

G53478

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 170c

Registered No. G53478

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 days
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Long Green,
(If outside city or town limits, write RURAL and give town)
(d) Street No..... (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME PARIS M. WELLS

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 5-1872

8. AGE: Years	Months	Days	If less than one day
75 72	2	9	..... hr. ..... min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER 12. Name Archie Wells
13. Birthplace Va.

MOTHER 14. Maiden Name Mary Alteiza
15. Birthplace Va.

16 (a) Informant Dewey Deweau
(b) Address Baldwin Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 15-47 (month) (day) (year)
(c) Cemetery or crematory Fork M.E. Cem
Location Fork Md.

18 (a) Funeral director Clarence E. Arthur
(b) Address Fork Md.

JUL 15 1947 (Date rec'd by registrar) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14, 1947, at 12 30 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar pneumonia

Due to .....

Other Conditions Subdural Hemorrhage Rt.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 6-4-47 at ..... M.
(b) Where did injury occur? Susquehenna Ave. & York Rd. Towson, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Ped. struck by auto.

23. Signature Earl L. Kelly M.D.
Medical Examiner.
Date signed 7-15-47

X

G53479

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G53479 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1630 E Fort Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1630 E Fort Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Kate Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife George H

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 31 1875

8. AGE: Years 71 | Months 6 | Days 13 | If less than one day hr. min.

9. Birthplace Eng Land (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name James White

13. Birthplace Eng Land

MOTHER 14. Maiden Name Not Known

15. Birthplace Eng Land

16 (a) Informant Mrs Sampie Bangs

(b) Address 1630 E Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-16-47 (month) (day) (year)

(c) Cemetery or crematory Holy Cross Cem

Location Brooklyn Md

18 (a) Funeral director Geo A Tagley

(b) Address Fulton Ave & Lafayette

JUL 16 1947 (Date received by Registrar) (b) Huntington Williams M.D.

VS 15e

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1947, at 19 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/2/47 1947, to 7/13 1947, and that I last saw her alive on 7/11 1947.

Immediate cause of death — Embolism associated with hypertensive Cardio Vascular disease.

Duration: 2 days.

Due to —

Other Conditions Asthmatic bronchitis (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Weiler M. D.

Address 1226 Hanover St. Date signed 7/15/47

G53180

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 9-D

G53180
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 614 Woodington Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 614 Woodington Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christina Elsie Hughes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Female	White	Widowed

6 (b) Name of husband Daniel T. Hughes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 24th 1873

8. AGE: Years	Months	Days	If less than one day
73	6	20	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name Richard F. Ender
13. Birthplace Neilly France

MOTHER
14. Maiden Name Elsie Krieger
15. Birthplace Germany

16 (a) Informant Miss Helen Hughes
(b) Address 614 Woodington Rd

17 (a) Burial (b) Date thereof 7/16/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Western
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 E. Paul St.

19 7/16/1947 (b) Huntington Williams
Date rec'd by Reg. (Sig.)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14th 1947, at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from January 1947, to July 14 1947, and that I last saw her alive on July 14 1947.

Immediate cause of death Chronic Myocarditis with Coronary sclerosis and myocardial collapse — Duration 1 yr.
Due to Arteriosclerosis — 7
Due to Senility — 3
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury

23. Signature Dr Walter Burrier M.D.
Address 3603 Edmondson Ave Date signed 7/15/47
M. D.

G53181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G53181
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Underlining is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — Sinai Hospital
(b) Street address
(c) Hospital or institution: Monument & Rutland Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2906 Reisterstown Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH BERNSTEIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Harry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26, 1898

8. AGE: Years	Months	Days	If less than one day
49	2	19	hr. min.

9. Birthplace Scotland
(Town, county, and state)

10. Usual Occupation

11. Industry or business House Work

FATHER
12. Name Benjamin Bernstein
13. Birthplace Lith

MOTHER
14. Maiden Name Jean Hirschman
15. Birthplace Lith

16 (a) Informant Harry Bernstein
(b) Address 2906 Reisterstown Road

17 (a) Burial (b) Date thereof July 16, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sharrei Thiloh Cem
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) JUL 16 1947 (b) Huntington Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1947 at 6:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 14 1947, to July 15 1947, and that I last saw h.e.r. alive on July 15 1947.

Immediate cause of death Metastatic Carcinoma, primary site is the breast. — Duration

Due to

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy Metastatic Carcinoma

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Allan J. Wolinsky M. D.
Address Sinai Hosp. Balt. MD Date signed 7/15/47

G53182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G53182

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2025 W. Fayette St. Balt.

(c) Hospital or institution: Bon Secours Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3715 Foster Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Girl Newlon (22) weeks Abortion)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/15/47

8. AGE: Years	Months	Days	If less than one day
[redacted]			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name John Milton Newlon

13. Birthplace Balt. Md.

MOTHER

14. Maiden Name Lillian Mary Ruggiero

15. Birthplace Balt. Md.

16 (a) Informant John M. Newlon (Father)

(b) Address 3715 Foster Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-16-46 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cem.

Location Eastern Ave. Rd.

18 (a) Funeral director Charles L. Zeiler

(b) Address 3605 Fait Ave. Huntington Williams, Mgr.

19 (a) JUL 16 1947 (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1947, at 4:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1947 to 5:15 PM 1947, and that I last saw h[illegible] alive on July 15 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Prematurity - 5½ mos.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature William F. Lucas M. D.

Address Bon Secours Hosp. Date signed 7-16-47

X

G53483

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G53483 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 708 S. Dean St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 708 S. Dean St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARVEY M. McVEY

3 (b) If veteran, name war: -----

3 (c) Social Security Account No. 717-07-7177

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edith E. McVey

6 (c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Dec. 28, 1886

8. AGE: Years: 60 | Months: 6 | Days: 16 17 | If less than one day: hr. min.

9. Birthplace: Baltimore Co., Md.
(Town, county, and state)

10. Usual Occupation: Hostler

11. Industry or business: Pennsylvania R.R.

FATHER
12. Name: John J. McVey
13. Birthplace: Pa.

MOTHER
14. Maiden Name: Martha Hoops
15. Birthplace: Unknown

16 (a) Informant: Edith E. McVey
(b) Address: 708 S. Dean St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-18-47 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn Mem.
Location: Eastern Ave. Rd.

18 (a) Funeral director: Charles L. Zeiler
(b) Address: 3605 Fait Ave.

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

JUL 16 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14th 1947, at 4:30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from July 11 1947 to July 14 1947 and that I last saw h[illegible] alive on July 10 1947

Immediate cause of death: Coronary Thrombosis — Duration: 7

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: J. W. Hoppel M. D.
Address: 1637 S. Carlton St. Date signed 7/15/47

G53184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

G53184
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Snowdentown
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALICE DAISY MYERS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Andrew Myers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1915

8. AGE: Years 32 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace: A.A. Co. Md
(Town, county, and state)

10. Usual Occupation: at Home

11. Industry or business

FATHER
12. Name: Wm F. Edwards
13. Birthplace: N.C.

MOTHER
14. Maiden Name: Mamie Warren
15. Birthplace: Md

16 (a) Informant: Andrew Myers
(b) Address: Slumberium - Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 17-47 (month) (day) (year)
(c) Cemetery or crematory: Mt Olivet
Location

18 (a) Funeral director: James Adams
(b) Address: 1142 W Stiles St

JUL 16 1947 (Date rec'd by local registrar) (b) Huntington Williams, M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14, 1947, at 1.03 a. M.

21. I certify that I took charge of the remains described above, held an partial autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hemorrhage due to Shot gun wound of lower abdomen and upper thighs
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-13-47 at 9.15 p. M.
(b) Where did injury occur? Glen Burnie, P.O. Snowdentown, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearms

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 7-14-47

X

G$3185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 75B

G53185 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green Sts.
(c) Hospital or institution: University Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1002 Ashburton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Betty Cooney.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Eugene F Cooney 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/24/1889

8. AGE: Years	Months	Days	If less than one day
57	7	21	hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation Home Maker

11. Industry or business

FATHER
12. Name Jones J Scott
13. Birthplace NC

MOTHER
14. Maiden Name Alice Parrish
15. Birthplace NC

16 (a) Informant Mrs E F Cooney
(b) Address 1002 Ashburton

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/18/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd

18 (a) Funeral director J. J. Fahey & Sons
(b) Address 318 Light St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/14/47 19 at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 12 19 47, to July 15 19 47, and that I last saw her alive on 15 July 19 47.

Immediate cause of death	Duration
Circumbolary Collapse	
Due to Bantis Syndrome terminal stages	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William L Byerly Jr M. D.
Address University Hospital Date signed 7-15-47

VS 150

MARGIN RESERVED FOR BINDING — Every item of information should be carefully supplied. TYPE or PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G53486

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. G53486

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1838 West Baltimore St.

(c) Hospital or institution: **********

(d) Length of stay in hospital or inst. (yrs., mos., or days) ****

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore Maryland (If outside city or town limits, write RURAL and give town)

(d) Street No. 1838 West Baltimore St. (If rural give location)

(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME NEVA T. EWING

3 (b) If veteran, name war **********

3 (c) Social Security Account No. **********

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John A. Ewing

6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr.) 4 / 12 /1885

8. AGE: Years	Months	Days	If less than one day
62	3	1	**********hrs. ********** min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER — 12. Name James A. Tharle

FATHER — 13. Birthplace Maryland

MOTHER — 14. Maiden Name Fannie K. Clark

MOTHER — 15. Birthplace Maryland

16 (a) Informant Miss F. Elizabeth Ewing

(b) Address 1838 West Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 16/47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Baltimore Maryland

18 (a) Funeral director F.B.WIPPERT & SON

(b) Address 1300 EUTAW PLACE ..17.c

JUL 16 1947 (Date rec'd by Registrar)

(b) [illegible]

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 13 th. 1947 at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1946 to July 13 1947 and that I last saw her alive on July 12 1947

Immediate cause of death Coronary Occlusion — Duration D

Due to Hypertension — Duration about 1 yr

Due to Cardio-Vascular disease — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Ernest G. Marr M. D.

Address 516 Cathederal St. Date signed 7/ /47

Dr. E.G.Marr.

G53187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V162B

Registered No. G53187

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland yes.
(b) Street address 2611 Spellman Road #1A
(c) Hospital or institution: Home. 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 14 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2611 Spellman Road #1A (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Jesse Wise

3 (b) If veteran, name war: no.
3 (c) Social Security Account No.: None 3

4. Sex: Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Florence Wise
6 (c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): Dec. 28th 1866

8. AGE: Years: 80 81 | Months: 7 | Days: 16 | If less than one day: 19 ½ hr. — min.

9. Birthplace: Montgomery County, Md. (Town, county, and state)

10. Usual Occupation: None (Received Pension)
11. Industry or business: None (Old age)

FATHER
12. Name: — Not. Known.
13. Birthplace: Not. Known.

MOTHER
14. Maiden Name: Not Known.
15. Birthplace: Not Known.

16 (a) Informant: Mrs Florence Wise
(b) Address: 2611 Spellman Road #1A

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 19, 47 (month) (day) (year)
(c) Cemetery or crematory: Bloomfield Chapel
Location: Highlandtown Md

18 (a) Funeral director: F.C. Wiegmann
(b) Address: Ellicott City Md

JUL 16 1947 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1947 at 12:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 12 1947 to July 16 1947 and that I last saw h alive on July 1947.

Immediate cause of death: Senility

	Duration
Due to	
Due to	
Other Conditions: None	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Jerry La-Lucks, M.D. (M.D.)
Address 303 Bridgeview Date signed 7-16-47

X

G53188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓128

Registered No. G53488

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3314 Parkington Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3314 Parkington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME H. BURTON BYE

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Edith E. W. Bye
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1897

8. AGE: Years	Months	Days	If less than one day
49	7	19	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Accountant
11. Industry or business R. S. Stern Co.

FATHER
12. Name Henry H. Bye
13. Birthplace Penna.

MOTHER
14. Maiden Name Clara Beehler
15. Birthplace Balto.

16 (a) Informant Mrs. Edith E. W. Bye
(b) Address 3314 Parkington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/17/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 JUL 16 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14, 1947, at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 16 1947 to July 14 1947, and that I last saw h~~im~~ alive on July 14 1947.

Immediate cause of death	Duration
Cardiac Decompensation	1 Day.
Due to Acute Pancreatitis	one month
Due to Acute Cholecystitis	one month
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation May 31, 1947
Major findings of operation: Pancreatitis Cholecystitis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Wilbur F. Pullman M. D.
Address 6 E. Biddle St Date signed 7/15/47

X

G53489

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193

Registered No. G53489

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3214 Tyndale Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK N. CALAFIORE

3 (b) If veteran, name war: World War II
3 (c) Social Security Account No.:
4 Sex: Male
5 Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Dorothy C. Calafiore (Nee Cochell)
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec. 25, 1911
8. AGE: Years 35 | Months 6 | Days 19 | If less than one day hr. min.
9. Birthplace New York, N. Y. (Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business Self

FATHER
12. Name Anthony Calafiore
13. Birthplace Italy

MOTHER
14. Maiden Name Unknown
15. Birthplace Italy

16 (a) Informant Mrs. Dorothy C. Calafiore
(b) Address 3214 Tyndale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/18/47 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Pk.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JUL 16 1947 (Date rec'd by Registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14, 1947, at 3:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Electrocution

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7/14/47 at 3:30 P.M. 16/4
(b) Where did injury occur? 1520 Edmondson Ave Balto MD
(c) Did injury occur at home, on farm, industrial place, in public place? Private Home While at work? No
(d) Means of injury Electrocuted while wiring house.

23. Signature George B. Merrill M.D. Medical Examiner.
Date signed 7/15/47

G53190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G53190

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Petersburg (If outside city or town limits, write RURAL and give town)
(d) Street No. 545 Taylor Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARION O. WOOLFORD

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mamie Woolford

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1877

8. AGE: Years 69 | Months 6 | Days 24 | If less than one day 25 hr. min.

9. Birthplace Cambridge, Md. (Town, county, and state)

10. Usual Occupation Sea Capt.

11. Industry or business

FATHER
12. Name Oliver S. Woolford
13. Birthplace Dorchester Co., Md.

MOTHER
14. Maiden Name Annie Richardson
15. Birthplace Cambridge, Md.

16 (a) Informant Mrs. Reginald Stembridge
(b) Address 208 Ridge Ave., Towson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/17/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JUL 16 1947 (a) (Local registrar) (b) Huntington Williams M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14, 1947, at 1.25 P M

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of 9th Dorsal Vert.
Due to Rupture of Liver
Rupture of Rt. Kidney

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-14-47 at 1 P. M.
(b) Where did injury occur? Sulphur Spring Road. Baltimore, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Auto and truck collision

23. Signature Earl L Knight M.D. (Medical Examiner.)
Date signed 7-15-47

G53491

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 166

G53491 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 918 Jordan alley (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-6-'93

8. AGE: Years 54 | Months 5 | Days 2 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Henry Williams
13. Birthplace

MOTHER
14. Maiden Name Kate Williams
15. Birthplace Richmond, Virginia

16 (a) Informant Sameul Williams
(b) Address 2650 Flora Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-16-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore, Maryland

18 (a) Funeral director Joseph L. Russ
(b) Address 1206 Druid Hill Ave.

JUL 16 1947 (a) (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8, 1947, at 5 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Bullet-wound of abdomen

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7/8/47 at 1:30 P.M.
(b) Where did injury occur? Middle of street at 900 blk Jordan alley
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Firearms

23. Signature George G. Merrill M.D. (Medical Examiner)
Date signed 7-9-47

G53492

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G53492
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution: South Baltimore Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3143 Dillon St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Malecki

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Julia Malecki
(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years 59 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation self-employed

11. Industry or business Confectionery

FATHER
12. Name William Malecki
13. Birthplace Poland

MOTHER
14. Maiden Name Elizabeth Gankoski
15. Birthplace Poland

16 (a) Informant Julia Malecki
(b) Address 3143 Dillon St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-18-47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Balto. Co.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern Ave

JUL 16 1947 (Date Rec'd by Registrar) (Huntington Williams M.D.) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1947, at 8:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 21 1947, to July 15 1947, and that I last saw him alive on July 15 1947.

	Duration
Immediate cause of death: Uremia	1 month
Due to: probable renal amyloidosis	?
Due to: Diabetes, gangrene of left foot	6 mos.
Other Conditions: Diabetes mellitus	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harold Dillon M. D.
Address 5... Balt. Gen. Hosp. Date signed 7-15-47

X

C58196 108519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C57193

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1032 N. Mount St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Thomas Wilson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26-1925

8. AGE: Years	Months	Days	If less than one day
21	6	20	hr. min.

9. Birthplace D.C.
(Town, county, and state)
10. Usual Occupation Home Wife
11. Industry or business

FATHER
12. Name Walter Price
13. Birthplace N.C.

MOTHER
14. Maiden Name Elizabeth Johnson
15. Birthplace Va.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/20/47 (month) (day) (year)
(c) Cemetery or crematory Cemetary
Location Fair Fax Co. Va.

18 (a) Funeral director Metropolitan Funeral Home
(b) Address 921 N. Mount St. Balto

19 JUL 16 1947 (Date rec'd by local registrar) (b) Remington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15, 1947 19 , at 8:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 17 1947, to July 15 1947 and that I last saw her alive on July 15, 1947.

	Duration
Immediate cause of death: respiratory failure	2 da.
Due to: Pulmonary tuberculosis	9 mos.
Due to:	
Other Conditions: none	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph J. Bowen Jr. M. D.
Address Baltimore City Hospital Date signed 7-16-47

C53194

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registration No. C53194

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3524 E Baltimore
(c) Hospital or institution: 26

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3524 E Baltimore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie A Rullman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widowed

6 (b) Name of husband or wife August H Rullman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 16 1861

8. AGE: Years	Months	Days	If less than one day
86	5	27 21	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name John Colley
13. Birthplace Baltimore

MOTHER
14. Maiden Name Fannie Maihl
15. Birthplace Baltimore

16 (a) Informant Mrs Nellie Paul
(b) Address 3524 E Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 17 1947 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave Balto Co Md

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St

JUL 16 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. (Registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1947, at 3.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-27 1947 to 7-13 1947, and that I last saw h e alive on 6-27 1947.

Immediate cause of death	Duration
Hypertensive cardio-vascular disease -	
Due to Leukemia	
Due to	
Other Conditions Fracturing left tibial condyle	6-27-47

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 26
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 6-27-47 at ? M
(c) Where did injury occur? 3524 E Baltimore (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Slipped & fell to floor

23. Signature Mildred J. Wilder M. D.
Address 1719 E Monument Place Date signed 7-14-47

J. Medeiros, M.D.

G53495

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G53495 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3049 Frisby St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3049 Frisby St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas C. Forrest.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Alice M. Forrest

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) July 21- 1875

8. AGE: Years 71 | Months 11 | Days 25 | If less than one day ..... hr. ..... min.

9. Birthplace Matthews Co Va
(Town, county, and state)

10. Usual Occupation Salt import Co

11. Industry or business

FATHER
12. Name Coleman Forrest
13. Birthplace Va

MOTHER
14. Maiden Name Dont Know
15 Birthplace Va

16 (a) Informant Carroll Forrest
(b) Address 3204 Waverly Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 18 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Pk
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St
(c) Date received by registrar JUL 16 1947 (Signature of registrar) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15th 1947, at 7.50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/13 1939, to July 15 1947, and that I last saw H/M alive on July 15 1947.

Immediate cause of death
Broncho-pneumonia
Myocardial degeneration
Due to arteriosclerosis — generalized

Duration
2 days
1 month
?

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John T. Klimas M. D.
Address 2623 E. Monument Date signed 7/15/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53496

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

G53496
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3006 E.Pratt Street.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3006 E.Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA B. GERSTMYER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John Gerstmyer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 21, 1864

8. AGE: Years	Months	Days	If less than one day
83	4	21	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER
12. Name John Bittdorf
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace Germany

16 (a) Informant Wm. Howard Gerstmyer
(b) Address 3053 Oak Forest Drive, #14

17 (a) Burial (b) Date thereof July 18th
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location City

18 (a) Funeral director Welsh Funeral Home
(b) Address 2006 Pleasant St.

19 (a) JUL 16 1947 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14, 1947; at 5.20 a M

21. I certify that I took charge of the remains described above, held an insp.& inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 7-15-47

G53197

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131a

Registered No. G53197

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3423 Claremont St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3423 Claremont St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William John Mc Congle

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-6167

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Julia Mc Congle

6 (c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) May 10-1910

8. AGE: Years 37 | Months 2 | Days 4 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, (Town, county, and state)

10. Usual Occupation Continental Can Co

11. Industry or business

FATHER 12. Name Wm J Mc Congle

13. Birthplace Ireland

MOTHER 14. Maiden Name Amelia Ritz

15. Birthplace Baltimore Md

16 (a) Informant Mrs Julia Mc Congle

(b) Address 3423 Claremont St

17 (a) Burial (b) Date thereof July 17. (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Catty

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2008 Eby ave

19 JUL 16 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14. 1947, at 7 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-5-46 19... to 7-14-47 19... and that I last saw h... alive on 7-12-47 19...

Immediate cause of death	Duration
Cerebral Hemorrhage	4 hrs
Due to Hypertensive Cardiovascular Renal disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John Costantini M.D. M. D.

Address 23[illegible] Loudon Av Date signed 7-14-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C53198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. C53198

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 222 Beal Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 222 Beal Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lallie L. Russell.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Widow

6 (b) Name of husband or wife David Russell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17, 1885

8. AGE: Years	Months	Days	If less than one day
61	8	27	hr. min.

9. Birthplace Pulaski, Virginia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Andrew Hall.
13. Birthplace Wythe County, Va.

MOTHER
14. Maiden Name Mary —
15. Birthplace Wythe County Va.

16 (a) Informant Mrs. M. Phillips
(b) Address 916 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-17-1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs. Katie R. Wallin
(b) Address 322 N. Schroeder St.

19 JUL 16 1947 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1947 at 6:37 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 12 1947 to July 13 1947 and that I last saw her alive on July 12 1947.

Immediate cause of death Cerebral hemorrhage

Duration 11 hrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address Date signed 7/18/47

McDonald
53199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G53199
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 69

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Balto Co.
(c) City or town Baltimore MD
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 Division St (If rural, give location) 2119 Madison Ave
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** John Henry Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Negro	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/10/1888

8. AGE: Years	Months	Days	If less than one day
59	6	4	hr. min.

9. Birthplace Baltimore Co
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Thomas D. Smith
13. Birthplace MD

MOTHER
14. Maiden Name Emily Virginia
15. Birthplace Long Green, Md

16 (a) Informant Thomas D. Smith
(b) Address 2119 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-17-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Wallace
(b) Address 322 N. Schroeder St.

JUL 16 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/14 1947, at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947 to July 14 1947 and that I last saw him alive on July 14 1947

Immediate cause of death: Cerebral Sclerosis

Due to: Heart disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. McDonald M. D.

Address Provident Hosp. Date signed 7/16/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93

Registered No. G53500

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 522 Baker St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 522 Baker St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lela Morrell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Married

6 (b) Name of husband or wife Herman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 02

8. AGE: Years	Months	Days	If less than one day
45	05	1	hr. min.

9. Birthplace Calvert Co. Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Graham
13. Birthplace Md.

MOTHER
14. Maiden Name Ella Hance
15. Birthplace Md.

16 (a) Informant Herman Morrell
(b) Address 522 Baker St

17 (a) Burial (b) Date thereof 7/16/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna. Ave

JUL 16 1947 Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/13 1947 at 1:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute dilatation of heart
Acute pulmonary edema
Due to Myocardial degeneration

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 7/14/47

G53501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G53501

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 939 Bennett Pl.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18

(e) Length of stay in Baltimore (yrs., mos., or days) 27yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 939 Bennett Place (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CARRIE FORD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Luther

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 10, 1900

8. AGE: Years 47 | Months 2 | Days 4 | If less than one day hr. min.

9. Birthplace Bennettsville, S. C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name Davis

13. Birthplace S. C.

MOTHER — 14. Maiden Name Loyalyia ?

15. Birthplace S. C.

16 (a) Informant Luther L. Ford

(b) Address 939 Bennett Place

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/19/47 (month) (day) (year)

(c) Cemetery or crematory Bennettsville

Location Bennettsville S. C.

18 (a) Funeral director William A. Jackson

(b) Address 916 Penna. Ave

(c) JUL 16 1947 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14, 1947, at 4a. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1946 to July 14 1947 and that I last saw h__ alive on July 14 1947.

Immediate cause of death

Cardio Vascular Chronic — Duration 1½ yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. H. Wells

Address 5154 Arlington Date signed 7/15/47

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G53502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G53502 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 118 S. Monroe St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 118 S. Monroe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John P. Lambert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Elizabeth N.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 23, 1886

8. AGE: Years 60 | Months 10 | Days 21 | If less than one day hr. min.

9. Birthplace Balto., Md.
(Town, county, and State)

10. Usual Occupation Stationary Engineer

11. Industry or business Retired

FATHER
12. Name Geo. F. Lambert
13. Birthplace Md.

MOTHER
14. Maiden Name Anna E. Yeager
15. Birthplace Md.

16 (a) Informant Mrs. Elizabeth N. Lambert
(b) Address 118 S. Monroe St.

17 (a) Burial (b) Date thereof 7/17/47.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Road

18 (a) Funeral director Harry H. Leitch
(b) Address 4101 Edmondson Ave

JUL 16 1947 (b) Huntington Williams, M.D.
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/14/47. 19 , at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1940 to July 14 1947.
and that I last saw h. alive on July 14 1947.

Immediate cause of death: Sudden death due to acute coronary occlusion — Duration

Due to

Due to

Other Conditions Hypertrophic arthritis — 7 yrs.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Morris B. Scheib, M. D.

Address Date signed

OVER

G53503

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164E

G53503 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 634 W Franklin St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vincent Tumminello (TUMMINELLO) Rd.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 5 1882

8. AGE: Years	Months	Days	If less than one day
65	5	9	hr. min.

9. Birthplace Italy (town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Salvatore Tumminello

13. Birthplace Italy

MOTHER 14. Maiden Name Rosaria ?

15. Birthplace Italy

16 (a) Informant Mr. Salvatore Tumminello

(b) Address 719 Brinkwood Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 17 1947 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Old Frederick Rd

18 (a) Funeral director Henry H Wright

(b) Address 4101 Edmondson Ave

JUL 16 1947 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1947, at 4:46 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Fracture of cervical spine, and fracture of ribs, right wrist

Due to and both tibia & fibulae.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury July 14, 1947 at 4:45 P.M.

(b) Where did injury occur? Edmonston Ave bridge at Fulton St

(c) Did injury occur at home, on farm, industrial place, in public place? Edmonston Ave Bridge Was at work? No

(d) Means of injury Jumped from bridge

23. Signature Edward J Hellrich M.D. Medical Examiner.

Date signed July 14, 1947

G53504

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

G53504
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 681 W. Fayette St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 681 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Cath Ewing Leonard Robinson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27 1879

8. AGE: Years 68 | Months 1 | Days 16,17 | If less than one day hr. min.

9. Birthplace W. Va. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mrs. Thynn
(b) Address 681 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/17/47. (month) (day) (year)
(c) Cemetery or crematory St Johns
Location Elliott City

18 (a) Funeral director Harry H. Leitzke
(b) Address 4101 Edmondson Ave
(c) Date rec'd by registrar JUL 16 1947 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/13/47. 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 11 1947. to July 13. 1947 and that I last saw him alive on July 13 1947.

Immediate cause of death	Duration
Acute Cardiac Dilatation	2 days
Due to Hypertensive Cardio Vascular Disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Harry Glassman M. D.
Address 2687 Westwood Ave Date signed July 15, 47

G53505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G53505 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 806 E. 41st St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mollie E. Waggner

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 13 1865

8. AGE: Years	Months	Days	If less than one day
82	5	2	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER
12. Name John T. Holt
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Marian Horney
15. Birthplace Baltimore Md

16 (a) Informant Emma H. Jenkins
(b) Address 3641 Greenmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 18-47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location E North Ave

18 (a) Funeral director John G. Mozan
(b) Address 3000 E Baltimore St

19 (a) (Date received) (Registrar) Huntington Williams M.D.

JUL 16 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1947 at 6A. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 4 1940 to July 15 1947 and that I last saw h[illegible] alive on 14 July 1947

Immediate cause of death	Duration
Coronary Thrombosis	Sudden
Due to Arteriosclerotic Cardio Vascular Disease	1940
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. W. Edmunds M. D.
Address 2746 The Alameda Date signed July 17

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The Physicians: please write the causes of death clearly and legibly. Give exact age in especially important.

G53506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G53506
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4702 Harford Rd.
(c) Hospital or institution:
Snyder Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4305 Glenarm Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Belle T. Smith

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Henry F. Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 3rd 1863

8. AGE: Years 83 | Months 10 | Days 12 | If less than one day hr. min.

9. Birthplace Balto. City Md
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name — Thompson
13. Birthplace —

MOTHER
14. Maiden Name — —
15. Birthplace —

16 (a) Informant Jesse Smith
(b) Address 4911 Midwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 18 47 (month) (day) (year)
(c) Cemetery or crematory Zion Luth. Cem.
Location Balto. Co. Md.

18 (a) Funeral director Lansdowne Funeral Home
(b) Address 7401 Belair Rd.

19 (a) Date received by registrar 7 18 1947 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16th 1947, at 4:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from January 15 1947, to July 16 1947, and that I last saw her alive on July 15 1947.

Immediate cause of death	Duration
Cardiac failure	2 days
Due to Cardio-vascular Hypertensive disease	10 years
Due to Arteriosclerosis	10 years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Michael J. Dausch M. D.
Address 1 W. Oneida Ave Date signed 7-16-47

VS 150

G53507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH. 13B

G53507 Registered No.

MARGIN RESERVED FOR BINDING

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore C.T.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 912 David Hill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Evelyn Adams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May, 1927

8. AGE: Years	Months	Days	If less than one day
20	2		hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Nick Adams
13. Birthplace Va.

MOTHER
14. Maiden Name Carrie
15. Birthplace Va.

16 (a) Informant Mrs. Adams
(b) Address 912 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/17/47 (month) (day) (year)
(c) Cemetery or crematory Nathalie
Location Virginia

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) JUL 16 1947 (Date received by Registrar) (b) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/13 1947, at 12 42 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pulmonary Tbc

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature J. P. Fulmore M.D.
Medical Examiner.
Date signed 7/15/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53508

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH · 1312

G53508 ✓ Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2521 Frederick Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life 39 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2521 Frederick Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) FULL NAME Mary Elizabeth Schaeffer
3 (b) If veteran, name war
3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife George Randall Schaeffer
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Aug. 25, 1907

8. AGE: Years 39 | Months 10 | Days 21 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name George Crotty
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Elizabeth McCowan
15. Birthplace Baltimore, Md.

16 (a) Informant George F. Schaffer
(b) Address 2521 Frederick Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/17/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto.

18 (a) Funeral director Wm Cook Inc
(b) 1217 St Paul St

19 (a) JUL 16 1947 Clayton Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1947, at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 13 1947 to July 15 1947, and that I last saw h[illegible] alive on July 15 1947.

Immediate cause of death Pulmonary Tuberculosis — Duration 3 mos +
Due to
Due to
Other Conditions Bronchopneumonia — Duration 1 day
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 1601 Liberty Heights Ave. Date signed 7/18/47

VS 150

G53509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G53509 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give name)
(d) Street No. 705 Washington Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Lorraine Rose Marie Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

Sex: Female | Color or race: White

6 (a) Single, ~~married, widowed, or divorced~~.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE-13-30

8. AGE: Years 17 | Months 1 | Days 12 | If less than one day — hr. — min.

9. Birthplace ACCOMAC, Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Smith
13. Birthplace BALTO. Md.

MOTHER
14. Maiden Name Madeleine P
15. Birthplace Va.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JULY 18, 1947 (month) (day) (year)
(c) Cemetery or crematory LORRAINE
Location WOODLAWN, Md.

18 (a) Funeral director WILLIAM COOT, INC
(b) Address 1217 ST. PAUL ST

JUL 18 1947

19 (a) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-15-47 at 7:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-7-47 to 7-15 1947 and that I last saw her alive on 7-15-1947

Immediate cause of death: Uraemia

Due to: Chronic Hypertensive Cardiovascular Disease — Duration: 1 year

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas E. VanHuetre JR MD M. D.

Address Johns Hopkins Hosp Date signed

VS 150

X

G53510 BC# 282553 BALTIMORE CITY HEALTH DEPARTMENT 160a G53510

CERTIFICATE OF DEATH

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Edgemere (If outside city or town limits, write RURAL and give town)
(d) Street No. 2504 Lakeview Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Shirley Jean Swoboda

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1947

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Swoboda
13. Birthplace Maryland

MOTHER
14. Maiden Name Regina Padgett
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address Johns Hopkins Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JUL 15 1947

18 (a) Funeral director Commissioner of Health
(b) Address
(a) JUL 16 1947 (Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7 1947, at 11:45PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 4 1947 to July 7 1947, and that I last saw her alive on July 7 1947.

Immediate cause of death	Duration
Prematurity	
intracranial hemorrhage	
Due to	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B C Williams M. D.
Address Johns Hopkins Hospital Date signed 7-8-47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53511

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G53511 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Caton & Wilkens Aves.

(c) Hospital or institution: St Agnes Hospital 9

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County —

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1124 Montpelier St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME James J. Crowe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1867

8. AGE: Years	Months	Days	If less than one day
80	1	15	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business —

FATHER

12. Name Stephen Crowe

13. Birthplace Ireland

MOTHER

14. Maiden Name Bridget Welsh

15. Birthplace Ireland

16 (a) Informant Ella Crowe

(b) Address 1124 Montpelier St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/19/47 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Beloit Road

18 (a) Funeral director Chas. P. Evans & Son

(b) Address 118 W. Mt. Royal Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

JUL 16 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1947, at 9.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 14 1947 to July 15 1947 and that I last saw him alive on July 15 1947.

Immediate cause of death	Duration
Cerebrovascular hemorrhage	7 days
Due to Hypertensive cardio-vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Herbert J. Loucks

Address St. Agnes Hospital Date signed 7/15/47

G53512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1320

G53512 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1525 Eutaw Place
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1525 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HELEN ELIZABETH WAUGH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife C. W. Waugh
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1920

8. AGE: Years	Months	Days	If less than one day
27	-	7	hr. min.

9. Birthplace Kensington, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Arthur Testlow
13. Birthplace Md.

MOTHER
14. Maiden Name Y. Elizabath Martinies
15. Birthplace Md.

16 (a) Informant Mr. Clarence W. Waugh
(b) Address 1525 Eutaw Place

17 (a) Burial (b) Date thereof 7 16 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Rockwell Md

18 (a) Funeral director WM. REUBEN PUMPHREY
(b) Address Rockville, Md.

19 (a) Date received by registrar 7 16 1947 (b) Registrar Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-16 1947, at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1945 to July 16 1947, and that I last saw h[illegible] alive on June 16 1947.

Immediate cause of death	Duration
Pulmonary Hemorrhage	1 day
Due to Pulm. Tuberculosis	5 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H W Jacobsen M. D.
Address 2310 Eutaw Place Date signed 7-16-47

G53513 Weininger G53513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 131a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3207 E Pratt St
(c) Hospital or institution: 26 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3207 E. Pratt St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Weininger (Cashmeyer)

3 (b) If veteran, name war ✓ 3 (c) Social Security Account No. 2

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife Single

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25 1875

8. AGE: Years	Months	Days	If less than one day
72	3	13	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Self.

FATHER
12. Name John Weininger
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Herpel
15. Birthplace Germany

16 (a) Informant Valentine Weininger
(b) Address 3313 Maryland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 19 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Wendell J. Riegel
(b) Address 312 S. Highland Ave

19 (a) [illegible] recd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1947, at 1 18 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 9 1947, to July 14 1947, and that I last saw h. (m.) alive on July 10 1947.

Immediate cause of death Cerebral Accident — Duration
Due to
Due to Cardio-Vascular Renal Disease
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Edward A. Flanigan Jr. M. D.
Address 7503 Fontaine Date signed 7-16-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C53514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. C53514

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lombard + Green Sts.

(c) Hospital or institution: University of Maryland Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore 21

(c) City or town Posey

(If outside city or town limits, write RURAL and give town)

(d) Street No. 28 Pelozar Ave

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) **FULL NAME** Molly Tellhelm

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Walter G Tellhelm

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 71 | Months | Days | If less than one day hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Wells Alexander

13. Birthplace Pennsylvania

MOTHER 14. Maiden Name Hannah Hidings

15. Birthplace Pennsylvania

16 (a) Informant Mrs. Jane Kurtz

(b) Address 28 Pelozar Ave

17 (a) Removal (b) Date thereof 7-16-47

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location Bellevue Park

18 (a) Funeral director John S. Connelly

(b) Address 711 Gaston Ave

19 JUL 17 1947 (b) Huntington Williams M.D.

(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16, 1947 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/11 1947 to 7/16, 1947 and that I last saw h. on alive on 7/16 1947

Immediate cause of death	Duration
Respiratory failure	
Due to Cerebral hemorrhage	24 hrs.
Due to Hypertension, arterio-sclerotic cardiovascular disease	Indefinite
Other Conditions Diabetes Mellitus	Indefinite

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature David J. Phillips M. D.

Address County Hosp. Date signed 7/16/47

VS 150

92 y

G53515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

G53515 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 821 Eutaw Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Rosenthal

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years 81 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-17-41 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel
Location Southern Ave.

18 (a) Funeral director Leo C. Levin Inc.
(b) Address 1439 E. Balto St.

19 JUL 17 1947 (Date rec'd by registrar) (Signature of registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16, 1947, at 11:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary edema due to arteriosclerotic cardiovascular disease

Due to

Other Conditions Decubitus ulcers. Healing fract. of left femur

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 4-18-47 3:30 P.M.
(b) Where did injury occur? Madison & Eutaw Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto.

23. Signature Earl R. Virg M.D. Medical Examiner

Date signed 7/16/47

G53516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

100 B

Registered No. G53516

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5204 Roland Avenue
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 - 13
(e) Length of stay in Baltimore (yrs., mos., or days) -

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5204 Roland Avenue (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Eugene August Widmaier

3 (b) If veteran, name war: no
3 (c) Social Security Account No. -

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Katherine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20, 1871

8. AGE: Years 75 | Months 11/10 | Days 20 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Caretaker
11. Industry or business Sharpe and Dohme

FATHER
12. Name John Widmaier
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina Monk
15. Birthplace Germany

16 (a) Informant Katherine Widmaier
(b) Address 5204 Roland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 19 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Loudon Park

18 (a) Funeral director Wm. Cook Inc.
(b) Address 1217 St. Paul Street

19 (Date rec'd by registrar) JUL 17 1947 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16, 1947 19 , at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to July 1947.
and that I last saw him alive on July 16 1947.

Immediate cause of death: Pulmonary Embolism — Duration
Due to: Thrombo-phlebitis, right leg
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William T. Hatfield M. D.
Address 5006 Roland Ave Date signed July 16 47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53517

CWK-112158

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 1931

Registered No. G53517

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 66 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore Towndale
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7823 Wise Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Hall (John Fayette Hall)

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 215-12-7643

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22-1880

8. AGE: Years	Months	Days	If less than one day
66	11	23	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business Belts. Salvage Co.

FATHER
12. Name Richard Hall
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Hartman
15. Birthplace Austria

16 (a) Informant Mrs. Walters
(b) Address 7823 Wise Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-19-47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director H. Dandes & Sons, Inc.
(b) Address North Ave. & Broadway

19 JUL 17 1947 (b) Signature of Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1947, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 14 1947 to July 15 1947, and that I last saw h. in alive on July 15 1947.

Immediate cause of death: Cerebral accident — Duration 2 Days
Due to: ? Thrombosis
Due to:
Other Conditions: Hypertensive Cardiovascular disease
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard T. Benford M. D.
Address Balt. City Hosp. Date signed 7-16-47

82a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G53518

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address EDGEWOOD NURSING HOME
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 - 5wks
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 203 S. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY AGNES WALLACE ANDREWS

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John Harvey Andrews
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Mar. 12, 1868

8. AGE: Years 78 | Months 3 4 | Days 2 | If less than one day hr. min.

9. Birthplace: Laurel, Pa. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: William Wallace
13. Birthplace: Pa.

MOTHER
14. Maiden Name: Mary Ann Heaps
15. Birthplace: Pa.

16 (a) Informant: Mrs. Clara Propf (daughter)
(b) Address: 7112 Wardman Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/17/47 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC
(b) Address: NORTH AVE. & BROADWAY

19 (a) JUL 17 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 4th 1947 to July 14 1947. and that I last saw h 4 alive on July 13 1947.

Immediate cause of death	Duration
Pulmonary Oedema	1
Due to My cerebral degenerat	4 yr
Due to Hypertension arterio Sclerosis	4 yr
Other Conditions Bilateral Pneumonia	4 days

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury

23. Signature: A. Flax, M. D.
Address 24 S. Monroe Date signed July 14/47

G53519 Multn 7080

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G53519

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 19-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 505 N. Mount St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen Hill
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Fe
5. Color or race N
6 (a) Single, married, (widowed) or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1/11/81
8. AGE: Years 66 Months 6 Days 2 If less than one day hr. min.
9. Birthplace Essex Co Va (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Arthur Cobbin
13. Birthplace Essex Co, Va

MOTHER
14. Maiden Name Martha Ellen Smith
15. Birthplace Essex Co. Va

16 (a) Informant Miss Rosa Hill
(b) Address 505 N. Mount
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-17-47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location
18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St
19 (a) Date received by local reg. JUL 17 1947 (b) Huntington Williams MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/13 1947, at 10 15 AM
21. I certify that death occurred on the date above stated; that I attended deceased from 7/10 1947 to 7/13 1947 and that I last saw h.r. alive on 7/13 1947
Immediate cause of death Carcinoma Ovaries — Duration 7
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature H. H. Williams M. D.
Address 74 W. Mt. Royal Ave Date signed 7/16/47

over

G53520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G53520

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1601 Hollins st
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-4
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 Hollins St (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Ferdinand A. Mauritz

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Katharine Mauritz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19-1878

8. AGE: Years	Months	Days	If less than one day
68	11	25 26	hr. min.

9. Birthplace Germany. (Town, county, and state)
10. Usual Occupation Stat. Engineer
11. Industry or business

FATHER
12. Name Henry Macritz
13. Birthplace Germany.

MOTHER
14. Maiden Name Henrietta Monke
15. Birthplace Germany

16 (a) Informant Mrs. Katharine Mauritz
(b) Address 1602 Hollins St

17 (a) Burial (b) Date thereof 7-17-47 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Pauls Violetville
Location Violetville.

18 (a) Funeral director Geo. K. Berger Jr.
(b) Address 1512 Hollins St.

19 JUL 17 1947 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14, 1947, at 4 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1947 to July 14 1947 and that I last saw h.im alive on July 14 1947.

Immediate cause of death: cerebral Hemmorrhage — Duration 1 day
Due to: Hypertensive cardio-vascular disease — Duration unknown
Due to: — Duration —
Other Conditions: —

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nathan Rosen M. D.
Address 206 S. Gilmor St. Date signed

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/61

Registered No. G53521

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rutland & Menumen
(c) Hospital or institution:
Sinai Hospital 5-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 103 N. Grant St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Beaty, Natalie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 6th 1916

8. AGE: Years	Months	Days	If less than one day
30	9	10	hr. min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Phillips
13. Birthplace Md

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant John W. Beaty
(b) Address 103 N. Grant St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-19th 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Leo Bilecoste
(b) Address 1210 N. Catherine Ave

19 (a) July 17 1947 Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1947, at 12:03 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 14 1947 to July 16 1947 and that I last saw he alive on July 16 1947.

Immediate cause of death	Duration
Pulmonary edema	3 days
Due to Pulmonary congestion	
Due to post hypophysectomy encephalopathy	3+ days
Due to Excess cranial Consumption	
Other Conditions Diabetes mellitus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy Pulmonary edema & congestion

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. A. Cohakey, M. D.
Address Sinai Hospital Date signed 7/16/47

87E

G53522

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G53522

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1111 Morris Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1111 Morris Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Jennie Gentry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11, 1877

8. AGE: Years 70 | Months 3 | Days 4 | If less than one day hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Nat Huskey
13. Birthplace N. C.

MOTHER
14. Maiden Name Not Known
15. Birthplace N. C.

16 (a) Informant Mrs Bessie Alston
(b) Address 310 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-18-47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co., Md.

18 (a) Funeral director Mrs. Francis A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) Filed [illegible] 1947 Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15, 1947, at 5:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/5 1947 to 7/15 1947, and that I last saw h[illegible] alive on 7/14 1947.

Immediate cause of death: Cardio-Vascular Renal Disease - Hypertension 14 yrs. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 600 Madison Ave 7/16/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53523

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

G53523 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1412 Northgate Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-9
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1412 Northgate Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles H. Pestner

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 8 1866

8. AGE: Years	Months	Days	If less than one day
80	11	7	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business Seaman

FATHER
12. Name John C. Pestner
13. Birthplace Germany

MOTHER
14. Maiden Name Mary E. Andrews
15. Birthplace Germany

16 (a) Informant Cintrey J. Bitter
(b) Address 142 Northgate Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 18 1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Road

18 (a) Funeral director John G. Moran
(b) Address 3000 E Baltimore St

19 JUL 17 1947 (Date rec'd by Registrar) Cunting for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1947, at 7 55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 7 1947 to July 15 1947 and that I last saw h alive on July 7 1947.

Immediate cause of death myocardial insufficiency
Due to diabetes
Due to diabetic gangrene left leg
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
✓ days ✓ hrs.
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. C. Tobiad
Address 447 N. Kenwood Ave Date signed 7/17/47 M. D.

X

G53524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G53524 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Carolina
(c) Hospital or institution: St. Josephs
(d) Length of stay in hospital or inst. (yrs., mos., or days) 32 days
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

26-6

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6548 Parnell Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Margaret E. Campbell

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife EARL R. CAMPBELL
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/22/94

8. AGE: Years	Months	Days	If less than one day
52	7	24	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name JAMES PHELPS
13. Birthplace UNKNOWN

MOTHER
14. Maiden Name LAURA —
15. Birthplace —

16 (a) Informant EARL R. CAMPBELL
(b) Address 6548 PARNELL AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7 18 47 (month) (day) (year)
(c) Cemetery or crematory OAKLAWN
Location BALTIMORE, MD

18 (a) Funeral director ROLAND L. FISHER
(b) Address 2112 DUNDALK AVE.

19 (a) JUL 17 1947 (Date Rec'd by Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 16 July 1947, at 8 53 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 14 June 1947 to 16 July 1947, and that I last saw her alive on 12 July 1947.

Immediate cause of death	Duration
Respiratory Failure	
Due to Toxemia	2wk
Due to Carcinoma of Cervix with Abdominal Metastasis	5yr
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 6/19/47
Major findings of operation: Obstruction of ileum, generalized metastasis
of autopsy: CA of cervix, ileal fistula, hydronephrosis, et

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James L. Shortt M.D.
Address St. Josephs Hospital Date signed 7/16/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. G53525

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: St. Joseph's Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 321 S. Central Avenue (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME PETER J. ZINGO

3 (b) If veteran, name war World War II

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anna

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 31, 1909

8. AGE: Years	Months	Days	If less than one day
37 mt	11	16	..... hr. ..... min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Night Club Manager
11. Industry or business

FATHER
12. Name Giuseppe Zingo
13. Birthplace Italy

MOTHER
14. Maiden Name Rosa LoPresti
15. Birthplace Italy

16 (a) Informant Anna Zingo (Wife)
(b) Address 321 S. Central Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-19-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.
18 (a) Funeral director Guardella Bros.
(b) Address 934 N. Monroe St.
19 (a) JUL 17 1947 (Date rec'd by registrar) (b) Evington Williams, M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16, 1947, at 9.15 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wounds of Brain and Abdomen

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-16-47 at 9.15 a. M. 6600 block Alta Ave.
(b) Where did injury occur? Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearms

23. Signature Earl L. Kaye M.D. Medical Examiner.
Date signed 7-16-47

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53526

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 124a

G53526 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rutland & Monument
(c) Hospital or institution: Sinai 9-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 wks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 3634 Old York Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Riley, Howard

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jany 16/1894

8. AGE: Years 53 | Months 6 | Days - | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Warehouseman

11. Industry or business Central Metal Co

FATHER 12. Name John E Riley

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Elizabeth Eckman

15. Birthplace Baltimore Md

16 (a) Informant Geneva Hare

(b) Address 3634 Old York Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 19/1947 (month) (day) (year)

(c) Cemetery or crematory Western
Location Baltimore Md

18 (a) Funeral director Harry J. Himmelrich

(b) Address 4204 Ridgewood Ave

19 (a) (Date rec'd by registrar) (b) Registrar.

JUL 17 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1947, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 8 1947 to July 16 1947, and that I last saw h. alive on July 16 1947.

	Duration
Immediate cause of death: Pulmonary Edema & Jaundice	3 wks
Due to: Cancer's Carcinoma	20 yrs
Due to: Alcoholism	30 yrs
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cancer's Carcinoma

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ray Cohadey M. D.
Address Sinai Hosp. Date signed 1947 July 16

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53527

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. G53527

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 945 W Fayette St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 945 W Fayette (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Eliza James
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation HW
11. Industry or business

FATHER
12. Name Perry Green
13. Birthplace Balto Md

MOTHER
14. Maiden Name Martha Brown
15. Birthplace Balto Md

16 (a) Informant Viola Vaughn
(b) Address 945 W Fayette St

17 (a) Burial (b) Date thereof July (month) (day) 47 (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Mt Calvary
Location Balto Md

18 (a) Funeral director Ignatius L Bowman Son
(b) Address 1084 N Mary St

19 (a) JUL 17 1947 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 13 1947, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased [illegible] 15 1947 to July 13 1947 and that I last saw h[illegible] alive on July 13 1947

Immediate cause of death Pneumonia, Infarction — Duration 3 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W H Watts
Address 5153 Remington Date signed 7/17/49

G53528

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G53528

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State S C (b) County
(c) City or town Charleston
(If outside city or town limits, write RURAL and give town)
(d) Street No. 11 Gadsden St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Warren Rise

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: W. L. Rise

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-21-10

8. AGE: Years 36 | Months 11 | Days 27 | If less than one day hr. min.

9. Birthplace S. C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Alexander
13. Birthplace S. C.

MOTHER
14. Maiden Name Mildred Palmer
15. Birthplace S. C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof July 17-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Charleston, S. C.
Location Charleston, S. C.

18 (a) Funeral director W. J. Jackson & Son
(b) Address 20 S. Paca - Balt. Md.

19 JUL 17 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1947 at 8:30 a M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947 to July 17 1947 and that I last saw her alive on July 17 1947.

Immediate cause of death: Cerebral Edema — Duration: 1 day.

Due to: Incomplete Removal of Brain Tumor (Meningioma)

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation July 13, 1947

Major findings of operation: Meningioma of Olfactory Groove

of autopsy Cerebral Edema; Tentorial Incision

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur B. Long M. D.

Address Johns Hopkins Hosp Date signed 7/17/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G53529

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1727 Darley Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1727 Darley Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Annie M. Davis

3 (b) If veteran, name war None
3 (c) Social Security Account No. 216-09-1740

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) April 7th. 1886

8. AGE: Years 61 | Months 3 | Days 8 | If less than one day ############ min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Seamstress
11. Industry or business Stadium Mfg. Co. Inc.

FATHER
12. Name Robert Davis
13. Birthplace England

MOTHER
14. Maiden Name Hanora Quinn
15. Birthplace Ireland

16 (a) Informant: Mrs. Eleanor Nossell
(b) Address 1727 Darley Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 18th, 1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave. Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) JUL 17 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15th 1947, at 8:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1945 to July 15 1947 and that I last saw h alive on June 17 1947.

Immediate cause of death Cardiac dilatation — Duration 1 hr
Due to Hypertension Arteriosclerosis — 3 yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. V. Cleft
Address 5010 Greenleaf Rd Date signed 7/16/47 D.

G53530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G53530

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 West 40th St
(c) Hospital or institution: Home for Incurables 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6yr 10 mo 7da
(e) Length of stay in Baltimore (yrs., mos., or days) 75yr 8mo 5da

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore #11 7
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 West 40th St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie Estelle Waxter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 11, 1871

8. AGE: Years 75 yrs | Months 8 mo | Days 5 days | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Teacher

11. Industry or business

FATHER
12. Name William Philip Waxter
13. Birthplace Bavaria, Germany

MOTHER
14. Maiden Name Elizabeth Deal
15. Birthplace Baltimore, Md.

16 (a) Informant Home for Incurables records
(b) Address 700 W 40th St., Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/18/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave Extended

18 (a) Funeral director John D. Mitchell & Son
(b) Address 1900 Eutaw Place

19 (a) JUL 17 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1947, at 8:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/9 1940 to 7/16 1947, and that I last saw h[illegible] alive on 7/15 1947.

Immediate cause of death	Duration
Coronary Occlusion	10 Hours
Due to Arteriosclerosis (Generalized)	15 Years
Due to	
Other Conditions Rheumatoid Arthritis	12 Years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Grafton Hergenroeder M.D.
Address 214 Medical Arts Bldg Date signed 7/16/47

X

G53531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G53531 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 353 Furrow St.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) ~~City or~~ town Glenarden, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. Greenbackville, Va
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie May Jones

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband ~~or wife~~ Timothy Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 22, 1871

8. AGE: Years	Months	Days	If less than one day
75	7	25	hr. min.

9. Birthplace Girdletree, Md
(Town, county, and state)
10. Usual Occupation Housedutier
11. Industry or business

FATHER 12. Name Stephen Payne
13. Birthplace Girdletree, Md
MOTHER 14. Maiden Name Rebecca Hill
15. Birthplace Girdletree, Md

16 (a) Informant Mrs Mae Hughes
(b) Address 353 Furrow St,

17 (a) Burial (b) Date thereof July 19 47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery or ~~crematory~~
Location Greenbackville Va

18 (a) Funeral director John O. Mitchell Home
(b) Address 1900 Eutaw Place

19 July 17 1947 (b) Huntington Williams, M.D.
(Registered by) (Attending physician or coroner)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1947 at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 21 1946 to July 17 1947. and that I last saw h[illegible] alive on July 16 1947.

Immediate cause of death	Duration
Cardio Vascular Failure	
Due to Anemia,	
Due to Senility	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hubert O Waters M. D.
Address 151 Wilkins Ave Date signed 7/17/47

G53532

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46M

G53532 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 25 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 603 N. CALVERT ST. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME James Farrell
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1888

8. AGE: Years	Months	Days	If less than one day
59	1	27	hr. min.

9. Birthplace FLORIDA (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name Gus Farrell
13. Birthplace FLORIDA

MOTHER
14. Maiden Name Annie Leonard
15. Birthplace FLORIDA

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Locati University Medical School JUL 17 1947
18 (a) Funeral director Commissioner of Health
(b) Address
JUL 17 1947 Washington Williams, M.D.
(Date rec'd by Registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 1947 at 12:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947 to July 3 1947 and that I last saw him alive on July 2 1947

Immediate cause of death PERITONITIS — Duration

Due to Ruptured Viscus

Due to CARCINOMA OF R.I. TRACT.

Other Conditions PRE-RENAL AZOTEMIA
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: NONE

of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Baty Scott
Address Mercy Hospital 7/5/47

X

G53533

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 166

G53533 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1365 N Calhoun Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Malchia THOMAS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1909

8. AGE: Years 38 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School JUL 17 1947

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) (Date rec'd by registrar) JUL 17 1947 Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 7, 1947, at 10 15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet-wound of heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-7-47 at 10 P. M.
(b) Where did injury occur? Calhoun & Harlem Sts
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearms

23. Signature George L. Merrill M.D. Medical Examiner.

Date signed 7/8/47

G53534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G53534 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2021 Hollins Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2021 Hollins Street
(If rural give location)
(e) Citizen of foreign country? No a (Yes or No)
If yes, name country

3 (a) FULL NAME THERESA A. HOWELL (NORATELL)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charles E. Howell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24, 1913

8. AGE: Years 34 | Months | Days 22 | If less than one day ... hr. ... min.

9. Birthplace: Baltimore Md.
(Town, county, and state)

10. Usual Occupation: Packer

11. Industry or business: Corkran Hill Co.

FATHER
12. Name: Henry B. White
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Anna Hohman
15 Birthplace: Baltimore, Md,

16 (a) Informant: Charles E. Howell
(b) Address: 2021 Hollins Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 18/47 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Baltimore Maryland

18 (a) Funeral director: F.B.WIPPERT & SON
(b) Address: 1300 EUTAW PLACE, 17

19 (a) (Date received by Registrar) (b) Registrar

JUL 17 1947 Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15th, 1947, at 9:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947, to July 15 1947, and that I last saw her alive on July 15 1947.

Immediate cause of death: Myocardial failure — Duration: 1 year

Due to: Cirrhosis of the liver — Duration: 2 months

Due to: — Duration:

Other Conditions: — Duration:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John F. Coolahan, M. D.
Address 24 N. Fulton Ave., Date signed 7/17/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53535

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. G53535

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5203 Ready Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DENZIL B. FULLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife: Maude Fuller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 13th 1905

8. AGE: Years 41 | Months 7 | Days 3 | If less than one day hr. min.

9. Birthplace: Keene N. H.
(Town, county, and state)

10. Usual Occupation: Tester

11. Industry or business: Westinghouse Co

FATHER
12. Name: Bert C. Fuller
13. Birthplace: Peterboro N. H.

MOTHER
14. Maiden Name: Alice M. Hill
15. Birthplace: Mason N. H.

16 (a) Informant: Mrs Maude M. Fuller
(b) Address: 5203 Ready Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 7/19/47 (month) (day) (year)
(c) Cemetery or ~~Crematory~~: Parkwood
Location: Parkville Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1347 St. Paul St

19 (a) JUL 18 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16, 1947, at 4:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h[illegible] alive on July 16 1947.

Immediate cause of death	Duration
Pulmonary edema, Left circulatory arrest	4 hrs
Due to Pneumonectomy, Rt.	24 hrs
Due to Carcinoma of lung Rt.	6 mos.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation July 15, 1947
Major findings of operation: carcinoma, Rt main bronchus
of autopsy: Pulm. edema

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edwin A. Adams Jr. M. D.
Address Univ. Hosp. Date signed 7/17/47

G53536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

G53536 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3502 Clifton Avenue
(c) Hospital or institution:
Fetterhoff Nursing Home 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
6 (c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2917 Clifton Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha M. Anderson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Married

6 (b) Name of husband or wife Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18, 1877

8. AGE: Years	Months	Days	If less than one day
70	3	28	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Saleslady
11. Industry or business Woman's Exchange

FATHER
12. Name Benjamin F. Miller
13. Birthplace Maryland

MOTHER
14. Maiden Name Maudella S. Gosweiler
15. Birthplace Maryland

16 (a) Informant Mrs. Grace B. Fairbanks
(b) Address 4311 Liberty Heights Avenue

17 (a) Burial (b) Date thereof 7/19/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

JUL 18 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16, 1947, at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/15 1944 to 7/16 1947 and that I last saw h[er] alive on 7/16 1947.

Immediate cause of death	Duration
Cerebral thrombosis	6 mths
Due to Hypertension	7
Due to Arteriosclerosis	7
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Robert A. Reiter M. D.
Address 340 E. Madison Ave Date signed 7/17/47

G53537

CWK-18438

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

Registered No. G53537

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Years
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1501 N. Fayette Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Talbert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife Maggie Talbert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 12-1886

8. AGE: Years	Months	Days	If less than one day
60	7	14	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business Own

FATHER
12. Name Samuel Talbert
13. Birthplace Maryland

MOTHER
14. Maiden Name Josephine Rigdon
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 7/19/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md.

18 (a) Funeral director Williams Cook Inc.
(b) Address 1217 St. Paul St.

19 JUL 18 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH July 16 1947, at 6:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 4 1936 to July 16 1947, and that I last saw h im alive on July 16 1947.

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Arteriosclerotic Heart Disease	
Due to	
Other Conditions Malnutrition	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Causes obvious

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Edw. R. Stephenson M. D.
Address Balto City Hosp. Date signed 7-17-47

C53538 Blk B-80145

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 157E

Registered No. C53538

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2040 E. Preston St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Thomas M. Chilcoat

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed,~~ or ~~divorced~~.
Male	White	Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age ___ years

7. Birth date of deceased (mo., day, yr.) June 5th 1947

8. AGE: Years	Months	Days	If less than one day
	1	12	....hr. ....min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business ———

FATHER
12. Name Thomas M. Chilcoat
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Jane King
15. Birthplace Balto. Md.

16 (a) Informant Thomas M. Chilcoat
(b) Address 2040 E. Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/18/47 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Towson Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) JUL 18 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/17/47 19.... at 3:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/19 1947 to 7/17 1947 and that I last saw him alive on 7/17/47 19....

Immediate cause of death Cardio-Respiratory failure — Duration .....

Due to Congenital Heart Disease — .....

Due to..... — .....

Other Conditions..... — .....

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operations: ———

of autopsy: Congenital Heart Disease

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature S. N. Steinberg

Address Sinai Hospital Date signed M. 7 D. 17/47

X

G53539 ENTWISLE

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G53539 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1521 E. 28th Dot. St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1521 E 28th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARIE Ida Entwisle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~ Married

6 (b) Name of husband ~~or wife~~ James F. Entwisle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 29th 1880

8. AGE: Years 67 | Months 3 | Days 18 | If less than one day hr. min.

9. Birthplace Fortress Monroe Va
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business at Home

FATHER
12. Name James Winne
13. Birthplace N. Y.

MOTHER
14. Maiden Name Jane Miller
15. Birthplace Hampton Va.

16 (a) Informant James F. Entwisle
(b) Address 1521 E. 28th St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 7/19/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lorraine
Location Balto. Co. Md.

18 (a) Funeral director Williams Cook Inc
(b) Address 1217 St. Paul St.

19 (JUL 18 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/17 1947 at 12:30 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Thrombosis

Due to Arteriosclerotic C.V. disease

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature R. J. Lalonde M.D.
Medical Examiner.
Date signed 7/17/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

653540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 653540

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2717 N. Calvert
(c) Hospital or institution: HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town City of Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2717 N. Calvert
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country NO

3 (a) FULL NAME WILLIE HAYDEN SURESCH

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No.: NONE

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Joseph B. Suresch
6 (c) If alive, give age XXX years

7. Birth date of deceased (mo., day, yr.): Jan. 1. 1876

8. AGE: Years 71 | Months 6 | Days 16 | If less than one day: hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business NONE

FATHER
12. Name Thomas G. Hayden
13. Birthplace Virginia

MOTHER
14. Maiden Name Elizabeth Douglas (?)
15. Birthplace England

16 (a) Informant Miss Adelina R. Suresch
(b) Address 2717 N. Calvert St., City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 - 19 - 47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore City

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108 W. North Ave., City

19 JUL 18 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1947, at 12 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1940 to July 17 1947, and that I last saw her alive on July 17 1947.

Immediate cause of death	Duration
Pulmonary Hemorrhage	45 Min.
Due to Chronic Bronchitis	7 yrs +
Due to	
Other Conditions Chronic Myocarditis Degeneration	7 yrs +

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Schneider M. D.
Address 1101 N. Wilson Ave Date signed 7-18-47

106 R

G53541

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 127a

Registered No. ~~G53541~~

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 123 W. Lanvale St. Baltimore Md.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Harold Vickery (THOMAS HAROLD VICKERY)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Kathleen McD. Vickery

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) August 25 1886

8. AGE: Years 65 | Months 10 | Days 29 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Edward Vickery
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Augusta Henderson
15. Birthplace England

16 (a) Informant Mrs T. H. Vickery (wife)
(b) Address 23 W Lanvale St

17 (a) buried (b) Date thereof 7-18-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Stewart Memorial
(b) Address 708 W North Ave.

19 JUL 18 1947 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1947, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 14 1947 to July 16 1947, and that I last saw him alive on July 16 1947.

Immediate cause of death: Peritonitis — Duration: 2 days
Due to: Acute Sappurative Cholecystitis — 1 week
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Acute Sappurative Cholecystitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel W Budd, M. D.
Address Union Memorial Hospital Date signed July 17

G53542

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$30

G53542 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4702 Harford Rd
(c) Hospital or institution:
Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) ?
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4702 Harford Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Jane Miller

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Lewis A. Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch 15-1855

8. AGE: Years	Months	Days	If less than one day
92	3 4	1 0	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Meaza
(b) Address 2909 Westfield Ave

17 (a) Burial (b) Date thereof July 18-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Md

18 (a) Funeral director Guy E. Beyer Jr
(b) Address 512 Hollins St.

19 JUL 18 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15th 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947 to July 12 1947 and that I last saw h[illegible] alive on July 12th 1947

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Karl Tramwell M.D.
Address 1623 E.N. Ave Date signed 7/17/47

VS 150

C53543 BC# D 83874

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

Registered No. C53543

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dr Kelly Av & Raymond St
(c) Hospital or institution: WBGH -
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Middle River (If outside city or town limits, write RURAL and give town)
(d) Street No. 125 N. Randolph Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Connell
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1 day

8. AGE: Years	Months	Days	If less than one day
		1	23 hr. 7 min.

9. Birthplace WBGH Hospital (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Calvin Connell
13. Birthplace Balt -

MOTHER
14. Maiden Name Marion DeFavor
15. Birthplace NC -

16 (a) Informant Hospital record
(b) Address WBGH -

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7-18-47. (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location Harmans Mill Rd. Ba. Co., Md

18 (a) Funeral director Charles L. Zeiler
(b) Address 2605 Fait Ave

19 (a) JUL 18 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/18/47 19 , at 10:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/14/47 to 7/15/47 and that I last saw h[illegible]m alive on 7/15/47

Immediate cause of death Respiration failure

Due to atelectasis

Due to

Other Conditions premature

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: Bilateral atelectasis

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. S. Wald M. D.
Address West Balt & Gar Ave Date signed 7/19/47

G53544

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1637

G53544 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1318 Poplar Grove st.
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(or) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1318 Poplar Grove st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilhelmina S. Michel

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: John Adam Michel (nee Carll)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 20, 1875

8. AGE: Years 72 | Months 0 | Days 26 | If less than one day hr. min.

9. Birthplace: Breman, Germany (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: - Carll
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Germany

16 (a) Informant: Mrs. Veronica A. Wingate
(b) Address: 4730 Liberty Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/19/47 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cem.
Location: Baltimore, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) JUL 18 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-16- 1947 at 7 55 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH (a) Acute Gastritis
Shock
Due to ingestion of iodine & mercurochrome -

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-16-47 at (?) 7 A. M.
(b) Where did injury occur? 1318 Poplar Grove st
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury: Ingested iodine & mercurochrome

23. Signature [signature] M.D. Medical Examiner.
Date signed 7-16-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53545

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

G53545 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1931 W. North Ave D.OA
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore P.Ky
(If outside city or town limits, write RUR and give town)
(d) Street No. 1931 W. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William M. Tyler

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Mae K. Tyler (nee Kernan)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31, 1889

8. AGE: Years	Months	Days	If less than one day
~~XXXX~~ 57	10	16 17	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation -

11. Industry or business Forest Theater

FATHER
12. Name Thomas T. Tyler
13. Birthplace Unknown

MOTHER
14. Maiden Name Nancy Simms
15. Birthplace Va.

16. (a) Informant Mrs. Mae K. Tyler
(b) Address 1931 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/19/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUL 18 1947 (Date rec'd by registrar) Huntington Williamson, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/17 19 47 at 5 30 AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Urinary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. J. Zulueta M.D.
Medical Examiner
Date signed 7/17/47

G53546

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G53546
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 432 E. 21st. St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 432 E. 21st. St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME REBECCA E. WEAVER.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Rufus Weaver
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1863

8. AGE: Years	Months	Days	If less than one day, hr.	min.
83	6	27		

9. Birthplace Maryland.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Smith,
13. Birthplace Maryland.

MOTHER
14. Maiden Name Susanna Schultz,
15. Birthplace Maryland.

16 (a) Informant Mrs. George M. Lindemon,
(b) Address 1902 Eutaw Place.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/19/47. (month) (day) (year)
(c) Cemetery or crematory Foreston Church
Location near Hampstead, Md.

18 (a) Funeral director Baird Lowenstein & Son
(b) Address 1902 Eutaw Place.

19 JUL 18 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17th. 1947 8.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1947 to July 17 1947. and that I last saw h alive on July 17 1947.

Immediate cause of death Acute myocarditis

Due to Chronic nephritis

Due to hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

Duration
3 Years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles S Mentzell M. D.
Address 1730 Linden Ave. Date signed

G53547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G53547

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3621 Elm Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3621 Elm Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Marion V. Williams

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Rachel C. Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18-1850

8. AGE: Years 97 | Months 1 | Days 28 | If less than one day hr. min.

9. Birthplace Carroll Co. Maryland (town, county, and state)

10. Usual Occupation Milk Dealer

11. Industry or business Retired 30 years

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Mrs. C. J. Haines

(b) Address 3621 Elm Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 19-1947 (month) (day) (year)

(c) Cemetery or crematory Finksburg

Location Finksburg, Maryland

18 (a) Funeral director Durgee Funeral Home

(b) Address 3631 Falls Road

19 (a) July 18 1947 (Date received by registrar) (b) [illegible] Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16- 1947, at 3.30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] 1946, to July 16 1947, and that I last saw him alive on July 16 1947.

Immediate cause of death Terminal Bronchio pneumonia — Duration 4 Days

Due to General Arteriosclerosis

Due to Senile Dementia, Hypostatic

Due to [illegible]

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]

Address 3614 Jocelyn Rd Date signed July 19 1947

M. D.

G53548 CMB 105369

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH · 13B

Registered No. G53548

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1500 N. Dallas St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Beulah Hall Summer or Summers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Separated

6 (b) Name of husband or wife Arthur Summer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 8, 1925

8. AGE: Years	Months	Days	If less than one day
21	10	8	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Randolph Hall
13. Birthplace Maryland

MOTHER
14. Maiden Name Nancy Armwood
15. Birthplace Maryland

16 (a) Informant Records - Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/19/47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk
Location

18 (a) Funeral director Joseph K. Lock Jr.
(b) Address 1304 N. Central Ave.

JUL 18 1947 (Date rec'd by registrar) (b) Huntington-Williams Mfg. Co.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1947, at 4pm M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 18 1946, to July 16 1947, and that I last saw h. alive on July 16 1947.

	Duration
Immediate cause of death: Respiratory failure	10 da.
Due to: Tuberculosis of lungs	2 yr.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph J. Bowen Jr. M.D.
Address Balto. City Hospitals Date signed July 17

X

G53549

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G53549 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 561- Mosher Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** ELEANORA ELEANOR MASON

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-16-2575

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
45		17	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Laundry
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Bertha James
(b) Address 939- Wetmer Ct.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/19/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director Herman A. Jackson
(b) Address 914 Pennsylvania Ave.

19 (a) JUL 18 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17, 1947 at 7.50 A M

21. I certify that I took charge of the remains described above, held an insp.&inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pagets Disease
Hypertensive C.V. Disease
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royster M.D. Medical Examiner
Date signed 7-17-47

G53550

BALTIMORE CITY HEALTH DEPARTMENT 83a ✓

CERTIFICATE OF DEATH · 14

Registered No. G53550

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 812 N. Calhoun
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Tenny Fowler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-28-79

8. AGE: Years 67 | Months 9 | Days 19 | If less than one day hr. min.

9. Birthplace S. C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Foster
13. Birthplace S. C.

MOTHER
14. Maiden Name Sarah ?
15. Birthplace S. C.

16 (a) Informant Rosanda
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 7/19/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. H. Gibson
(b) Address 1303 Pressman St

JUL 18 1947
(Date rec'd by registrar) (b) Funeral Director's Address

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1947 at 7.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1947 to July 17 1947 and that I last saw deceased alive on July 17 1947

Immediate cause of death	Duration
Tuberculous Meningitis	
Due to Generalized Tuberculosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thornton G. Burd M.D.
Address Johns Hopkins Hosp Date signed July 19 1947

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

G53551 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st Sts
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) almost 16 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Halethorpe (If outside city or town limits, write RURAL and give town)
(d) Street No. 5700 Second Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME William Nichols Stowell

3 (b) If veteran, name war: SAW
3 (c) Social Security Account No.: ---

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Marion Bauer Stowell
6 (c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): June 19, 1876

8. AGE: Years 71 | Months - | Days 28 | If less than one day: hr. min.

9. Birthplace: Balto, Md. (Town, county, and state)

10. Usual Occupation: None - retired

11. Industry or business: U.S. Navy Yard, Wash. D.C.

FATHER
12. Name: Joseph Wm. Stowell
13. Birthplace: Balto, Md.

MOTHER
14. Maiden Name: Josephine Nichols
15. Birthplace: Balto, Md.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 7/21/47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cemetery
Location: Baltimore, Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) Huntington Williams, M.D. (Date received by registrar) (b) Registrar

JUL 18 1947

VS-150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH July 17 19 47, at 2:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 16 19 47 to July 17 19 47, and that I last saw h in alive on July 17 19 47.

Immediate cause of death: Mesenteric Thrombosis with Infarction of Small Intestine — Duration: Few days

Due to:

Due to:

Other Conditions: Hepatic Cirrhosis — Duration: Unknown

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Henry Grabstald, (A.D.) M. D.
Asst. Surg (R) USPHS
Address: Date signed 7-17-47

99

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53552
396345

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1316

✓ G53552
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 513 W. Lafayette Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Tyler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	black	married

6 (b) Name of husband or wife William Tyler
6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) 2/20/1901

8. AGE: Years	Months	Days	If less than one day
46	4	26	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Agustus Crowdy
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Forman
15. Birthplace Md.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/21/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore, Nat'l.
Location Balto. Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave

19 1947 Rec'd by registrar (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July-16 1947 at 3 35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-15- 1947 to 7-16- 1947 and that I last saw her alive on 7-16- 1947.

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to Arteriosclerosis, Hypertension	
Due to Angina Pectoris	
Other Conditions Heart failure	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address Johns Hopkins Hosp Date signed 7/21/47

X

G53553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G53553
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 2 3 D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. (710 Alexander St) 716 Allendale St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ORVILLE SHOEMAKER

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years	Months	Days	If less than one day
46			hr. min.

9. Birthplace
(Town, county, and state)
10. Usual Occupation SEAMAN
11. Industry or business Ships

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof 7-18-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Matthia
Location O'Donnell St.

18 (a) Funeral director Lilly & Zeiler Inc
(b) Address 403 S. Wolfe St.

19 (a) 7 18 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12, 1947, at 5.45 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Thrombosis
Acute edema of lungs
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur in home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 7-14-47

G53554

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

G53554 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 806 S. Robinson St.
(c) Hospital or institution: NONE
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 806 S. Robinson St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country — — —

3 (a) FULL NAME Anna Olver

3 (b) If veteran, name war	3 (c) Social Security Account No.
— — —	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Hunter Olver
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 5-2-1875

8. AGE: Years	Months	Days	If less than one day
72	2	14	— hr. — min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name John Hanna
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Schuman
15. Birthplace Maryland

16 (a) Informant Agnes Olver
(b) Address 806 S. Robinson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-19-47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave.

18 (a) Funeral director Lilly + Zeiler Inc.
(b) Address 403 S. Wolfe St.

19 (a) (Date received by registrar) (b) Registrar
JUL 19 1947
V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1947, at 11 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 25 19 47 to July 16 19 47, and that I last saw h. L. alive on July 16 19 47.

Immediate cause of death	Duration
Acute Cardiac Failure	
Due to Cardio Vascular Renal Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward A. Flannigan M. D.
Address 3503 Fait Ave. Date signed July 17 1947

G53555

BALTIMORE CITY HEALTH DEPARTMENT

Talbott

CERTIFICATE OF DEATH 94a

Registered No. G53555

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Greene
(c) Hospital or institution: University Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14da
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 905 W. Saratoga St apt 4.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Talbott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Married

6 (b) Name of husband or wife Bessie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business Linen Shop

FATHER 12. Name George Talbert

13. Birthplace Maryland

MOTHER 14. Maiden Name Minnie Talbert

15. Birthplace Baltimore Md

16 (a) Informant Bessie E. Talbert

(b) Address 905 Saratoga st

17 (a) (Burial, cremation, or removal) (b) Date thereof 7/21/47 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Location Annapolis Ave

18 (a) Funeral director Leonard W. Jalen

(b) Address 1047 Myrtle ave

19 Date received JUL 18 1947 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-17 1947 at 2:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-3 1947 to 7-17 1947 and that I last saw him alive on 7-17 1947.

Immediate cause of death	Duration
Myocardial infarction then	
Due to arteriosclerosis & coronary insufficiency	
Due to	
Other Conditions Possible Addison's Disease	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Calvin B. Kearney M. D.

Address University Hospital Date signed 7-18-47

X

G53556

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 94a

Registered No. G53556

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2751 Invalide Ave.
(c) Hospital or institution: 94

(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1511 Carswell st
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Harry Dasch (Daesch)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Ethel

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 12 1881

8. AGE: Years	Months	Days	If less than one day
61	0	5	..... hr. ..... min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Labor Foreman

11. Industry or business Salt

FATHER
12. Name Unknown Dasch
13. Birthplace Unknown

MOTHER
14. Maiden Name Elizabeth Unknown
15. Birthplace Unknown

16 (a) Informant Mrs Carroll D Creston
(b) Address 2292 Echodale Rd

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 7/21/47 (month) (day) (year)

(c) Cemetery or crematory Loraine
Location Woodlawn Md

18 (a) Funeral director Pashon & Doyle
(b) Address 1217 Eutaw St

19 (a) JUL 18 1947 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-17-1947 at 6 25 P.M.

21. I certify that I took charge of the remains described above, held an Aug + Ins thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary artery disease

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Earl L Royer M.D.
Medical Examiner.
Date signed 7-18-47

G53557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G53557

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1218 Hanover st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1218 Hanover st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Ellsworth Thomas

3 (b) If veteran, name war /

3 (c) Social Security Account No. 218-07-2450

4. Sex: Male

5. Color or race: White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of ~~husband or~~ wife: Louise Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11th 1871

8. AGE: Years 76 | Months 1 | Days 6 | If less than one day hr. min.

9. Birthplace Dorchester Co. Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Elevator Operater

FATHER
12. Name (Unknown) Thomas
13. Birthplace "

MOTHER
14. Maiden Name Marye Thomas
15. Birthplace Dorchester Co. Md.

16 (a) Informant Mrs. August Nicklas
(b) Address 1218 Hanover St

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 7/19/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Sudden
Location Dorchester Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St Paul St.

19 (a) July 18 1947 (b) Huntingtown Witness (Signature) (Address)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17th 1947, at 12 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/11/ 1947 to 7/17/ 1947 and that I last saw him alive on 7/17/ 1947

Immediate cause of death: Hypostatic pneumonia following hypertensive — Duration: 6 mos.
Due to: cardio vascular disease.
Due to:
Other Conditions: General and cerebral arterio sclerosis. — ?
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Deibel M. D.
Address 1226 Hanover St. Date signed 7/17/ 1947.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 57E

Registered No. G53558

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hayden + Dudeland
(c) Hospital or institution: East Baltimore Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County * *
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1223 Poplar Grove St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret R. Murphy

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John T Murphy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 6 - 1882

8. AGE: Years: 64 | Months: 10 | Days: 10 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business City Welfare

FATHER
12. Name John Nixon
13. Birthplace Ireland

MOTHER
14. Maiden Name Sallie Hignan
15. Birthplace Ireland

16 (a) Informant J. Jerome Murphy
(b) Address 5411 Purlington Way

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 19 (month) (day) 47 (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Chas. F. Evans & Son
(b) Address 116 W Mt Royal Ave

19 (Date rec'd by registrar) JUL 18 1947 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 16 July, 1947 at 4:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1 July 1947 to 16 July 1947 and that I last saw h[illegible] alive on 16 July 1947

Immediate cause of death: Cardio Resp Failure — Duration:

Due to: Coron. Pulmonary Embolus.

Due to: Coronic Thrombosis?

Other Conditions: Right side & abdom. explan. mass - etio. undet.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leo A. Stolle Jr. M. D.
Address East Baltimore Gen Hosp Date signed 7/16/47

111a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

653559

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registration No. 653559

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1009 Linden Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1009 Linden Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dora Anna Shelton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Robert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1874

8. AGE: Years 72 | Months 9 | Days 4 | If less than one day hr. min.

9. Birthplace Rotaway Co. Va (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name David Fitzgerald
13. Birthplace King & Queen Co. Va

MOTHER
14. Maiden Name Elizabeth
15. Birthplace King & Queen Co. Va

16 (a) Informant Mary Elizabeth Chapman
(b) Address 1009 Linden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 19, 19 47 (month) (day) (year)
(c) Cemetery or crematory Family Lot
Location Hillville, Va

18 (a) Funeral directors Chas. H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) (Date received by Registrar) JUL 18 1947 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947, to July 16 1947, and that I last saw h[illegible] alive on July 16 1947.

Immediate cause of death	Duration
Hypostatic Congestion and Pneumonia	7
Due to Arterio Sclerotic Heart Disease	
Due to Arteriosclerosis and Hypertension	
Other Conditions Multiple Decubitus Ulcers	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Duncan R. Julian

Address 434 E. 23rd St. Date signed 7/18/47

G53560 11

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G53560

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County N
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1409 David Hill (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mary I. Murden nee Peaker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: N

6 (a) Single, married, widowed or divorced.

6 (b) Name of husband or wife Jacob A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/7/1896

8. AGE: Years 50 | Months 7 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Ret. School Teacher

11. Industry or business Public school

FATHER
12. Name Joseph T. Peaker
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Lottie Jackson
15. Birthplace Balto. Md.

16 (a) Informant Estelle Baker Holsen
(b) Address 1409 David Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 19, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. George N. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) Date received JUL 19 1947 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/16 1947, at 8:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/14 1947 to 7/16/47 19 ; and that I last saw h alive on 7/16 1947.

Immediate cause of death: Uremia — Duration

Due to Hypertensive C-V Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George McDonald

Address 644 N Carey Date signed 7/19/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53561 (HUNTER)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G53561

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St.
(c) Hospital or institution:
Home for the Aged Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Hunter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	W.

6 (b) Name of husband or wife Emma Dussel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1857

8. AGE: Years	Months	Days	If less than one day
90	2	13	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Adam Hunter
13. Birthplace

MOTHER
14. Maiden Name Anna Gallagher
15. Birthplace

16 (a) Informant Lillie Lukes / Mrs Dawson
(b) Address 1200 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 19, 1947 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 E. Biddle St

19 (a) JUL 18 1947 (Date received by registrar) Huntington Williams, M.D. (Address)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 1947, at 10:[illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from July 12 1947, to July 18 1947, and that I last saw h.im alive on July 18 1947.

Immediate cause of death	Duration
Chr Myocarditis	10 years.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. S. Hardesty M. D.
Address 4810 Belair Rd Date signed July 18/47

VS 150

X

C53562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. C53562

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Ln.
(c) Hospital or institution:
Home for the Aged Room 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Diehl

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Louis Diehl

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1864

8. AGE: Years 82 | Months 8 | Days 6 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Andrew Miller
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret
15. Birthplace Germany

16 (a) Informant Estelle Linder 1200 Valley Ln
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 19 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Cross R.C.
Location

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 E. Biddle St.

19 (a) (Date received by Registrar) July 18 1947 Huntington Williams Registrar

VS 150 4810 Belair Road

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1947, at 5:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947, to July 17 1947, and that I last saw h[illegible] alive on July 16 1947

Immediate cause of death: Ch myocarditis — Duration 2 yrs.
Due to: Ch arthritis
Due to: Arterio Sclerosis
Other Conditions: by intension

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J S Hardings M. D.
Address 4810 Belair Rd Date signed July 18 1947

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

653563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 83a

Registered No. 653563

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Butland & Monument
(c) Hospital or institution: Sinai Hos. 77
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3303 Rosalie Av.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna A. Wright

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife James A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9-1879

8. AGE: Years	Months	Days	If less than one day
68		8	hr. min.

9. Birthplace New York
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Patrick Flinn
13. Birthplace Ireland.

MOTHER
14. Maiden Name Kath. Mulvey
15. Birthplace Ireland.

16 (a) Informant John Wright
(b) Address 20 W. Fredrick Ave

17 (a) Burial (b) Date thereof July 21-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Woodlawn Md.

18 (a) Funeral director John A. McCann
(b) Address 4201 Monument Ave

19 (a) July 18 1947 Registrar Washington Millspaugh, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1947, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 9 1947, to July 17 1947, and that I last saw her alive on July 17 1947.

Immediate cause of death	Duration
Infection due to generalized sepsis and edema	
Due to decubitus ulcers	
Due to hemiplegia following cerebral hemorrhage	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy decubitus ulcers cerebral hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marvin Shapiro
Address Sinai Hospital Date signed 7/17/47

G53564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G53564

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Da 4 mos 17
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 500 Longwood St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** William Boyd Thomson
3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.: ?
4. Sex: M
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: ?
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): ? 1899
8. AGE: Years 48 | Months | Days | If less than one day hr. min.
9. Birthplace: ? (Town, county, and state)
10. Usual Occupation: Lady Nurse
11. Industry or business: Nursing
FATHER 12. Name: William Thompson
13. Birthplace: Va.
MOTHER 14. Maiden Name: Lucy Thompson
15. Birthplace:
16 (a) Informant: Baptist Sisters
(b) Address 411 George Street
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-12-47 (month) (day), (year)
(c) Cemetery or crematory: Balto. National
Location: ?
18 (a) Funeral director: Adolph Halstad
(b) Address: Balto. Md. 917 Druid Hill Ave.

JUL 18 1947
Date rec'd by registrar

Huntington Williams, M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-15-47 19 at 5:40 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 7-15 1947 to 19 , and that I last saw h.e.she alive on 7-15 1947.

Immediate cause of death: Cerebral Hemorrhage — Duration
Due to: Cardiac Insufficiency
Due to: Hypertension Disease
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: 7-16-47

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature: William A. Graf M. D.
Address: Mercy Hosp. Date signed: 7-16-47

G53565

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G53565

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5718 Pimlico Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5718 Pimlico Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** George J. Clark

3 (b) If veteran, name war ---
3 (c) Social Security Account No. ---

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Margret Kemper Clark
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20 1870

8. AGE: Years 76 | Months 11 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Retired
11. Industry or business Furrier

FATHER
12. Name John C lark
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Margret Kemper
15. Birthplace Baltimore Md.

16 (a) Informant Mrs Margret Eisenger
(b) Address 5057 Wright Ave

17 (a) Burial (b) Date thereof 7-19-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Loring Byers
(b) Address 5005 Park Hgts. Ave

19 (a) JUL 18 19 47 Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 19 47 5:30 P.M. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 16 1946 to July 16 1947 and that I last saw h alive on July 16, 47

Immediate cause of death	Duration
Coronary Occlusion	3 hours
Generalized Arterioscler-	
Osis	Indefinite
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sherman A Ward M.D.
Address 2601 Manhattan Av Date signed 7/16/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C53566

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. C53566

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5103 Springlake Way
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH JOHN ROBERTS

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife May Clark Roberts
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 28, 1889

8. AGE: Years	Months	Days	If less than one day
58	3	18	hr. min.

9. Birthplace Naugatuck, Conn.
(Town, county, and state)
10. Usual Occupation Physician
11. Industry or business

FATHER
12. Name John Roberts
13. Birthplace Wales

MOTHER
14. Maiden Name Catherine Kelly
15. Birthplace Ireland

16 (a) Informant Mrs. May C. Roberts
(b) Address 5103 Springlake Way

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/19/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by Registrar) JUL 18 1947 Washington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 9 - 1947 to July 17 1947 and that I last saw h. alive on July 16 1947

Immediate cause of death	Duration
Coronary Thrombosis	1 hr.
Due to	
Due to	
Other Conditions Cardio Vascular Disease (Include pregnancy within 3 months of death)	Known 2 wks.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank Masino M. D.
Address 1129 St Paul St Date signed July 18/47

G53567

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

469

Registered No. G53567

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla (b) County
(c) City or town Miami
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3170 South West 8th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John L. MacAvoy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-10-85

8. AGE: Years	Months	Days	If less than one day
61	11	8	hr. min.

9. Birthplace Pa (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER 12. Name Thomas D. MacAvoy
13. Birthplace Pa

MOTHER 14. Maiden Name Mary Louise Shaffer
15. Birthplace Pa

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 7/21/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Harrisburg, Pa.
Location

18 (a) Funeral director Oehlinger
(b) Address 20-23 E. Madison St.

JUL 18 1947 Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 1947 at 10 00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1947 to July 18 1947 and that I last saw living on July 18 1947

Immediate cause of death	Duration
Carcinoma of head of the pancreas	
Due to	
Due to	5 MO.
Other Conditions Cachexia	

(Include pregnancy within 3 months of death)
Date of operation 7-3-47
Major findings of operation: Ca of pancreas
of autopsy: "

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature A. S. Morrow
Address JHH Date signed 7-18-47 M. D.

VS 150

G53568

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

G53568 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General (Annex)
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2323 N. Monroe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William H. Flohr (FLOHR)

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Mary J. Flohr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 20, 1860

8. AGE: Years	Months	Days	If less than one day
87	3	26	hr. min.

9. Birthplace Linebrough, Md. (Town, county, and state)
10. Usual Occupation Retired Painter
11. Industry or business

FATHER
12. Name Gustave Flohr
13. Birthplace unknown

MOTHER
14. Maiden Name Neller
15. Birthplace unknown.

16 (a) Informant Mrs. Geo. W. Coggins.
(b) Address 3214 Auchentroly Terr.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof 7/20/47 (month) (day) (year)
(c) Cemetery or crematory Bethlehem Home
Location Stelty, Pa.

18 (a) Funeral director C. V. Grum Lemmon
(b) Address 4611 Park Heights Ave.

19 (a) JUL 18 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16, 1947, at 6 15 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH (a) Cerebral Edema
(b) Generalized Arteriosclerosis
Due to
Other Conditions Decubitus Ulcers
of Buttocks.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury 4-25-47 at 9:35 A. M.
(b) Where did injury occur? Pentagon Town Road and Uptown Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto.

23. Signature Emil V. Rogh M.D.
Medical Examiner
Date signed

G53569

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54B

Registered No. G53569

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Washington
(c) City or town ~~Hag~~ Hagerstown Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Nellie W. Sprecher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife A Roy Sprecher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Richard
13. Birthplace Maplevale Md

MOTHER
14. Maiden Name No Record
15. Birthplace " "

16 (a) Informant Roy Sprecher
(b) Address Hagerstown Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-20-47 (month) (day) (year)
(c) Cemetery or crematory Rose Hill
Location Hagerstown Md.

18 (a) Funeral director C. K. Coffman
(b) Address Hagerstown Md.

19 JUL 19 1947 (b) (Date rec'd by Registrar) Washington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 1947, at 1:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1947 to July 18 1947, and that I last saw h. alive on July 18 1947.

Immediate cause of death	Duration
Cardiac failure;	
Due to Respiratory failure	
Due to Medullary compression	over
Other Conditions Rt. cerebellar hemisphere tumor.	

(Include pregnancy within 3 months of death)
Date of operation July 16, 1947.
Major findings of operation: Cerebral hydrocephalus
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Robert C. Hunter M. D.
Address Univ. Hosp. Date signed July 19 1947

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53570

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

49a

Registered No. G53570

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1 Madison Ave West Linden
(c) Hospital or Institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-31-47 to 7/18/47
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Westminster Md
(If outside city or town limits write RURAL and give town)
(d) Street No. 32 E. Green St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Lydia E. Blizzard

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
F	W	(Widowed)

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 26 1876

8. AGE: Years	Months	Days	If less than one day
70	6	20	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Asbury Overton
13. Birthplace Maryland

MOTHER
14. Maiden Name Belinda Yingling
15. Birthplace Maryland

16 (a) Informant Harland H Blizzard
(b) Address Westminster, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 21-1947 (month) (day) (year)
(c) Cemetery or crematory Bethel Cem.
Location Carrollton, Md.

18 (a) Funeral director H H Bankard Sons
(b) Address Westminster, Md.

JUL 19 1947 (Date rec'd by Registrar)

(b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/18/47 19 . at 9:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/14/47 19 . to 7/18/47 19 , and that I last saw h[illegible] alive on 7/18/47 19 .

Immediate cause of death Generalized Carcinomatosis — Duration: one week
Due to —
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —
23. Signature Lyman C. Wolcott M. D.
Address Med Gen Hosp Date signed 7/18/47

G53571

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G53571

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 126 N Luzerne Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6'
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 126 N Luzerne ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Sponheimer

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Sophie Sponheimer
6 (c) If alive, give age 71 years
7. Birth date of deceased (mo., day, yr.) 2/21/1876

8. AGE: Years	Months	Days	If less than one day
71	4	23	..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Restaurant
11. Industry or business Retired

FATHER
12. Name Geo Sponheimer
13. Birthplace Germany

MOTHER
14. Maiden Name Dont Know
15. Birthplace Germany

16 (a) Informant Geo Sponheimer
(b) Address 137 N Monroe ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/19/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Rural
18 (a) Funeral director Ulrich Funeral Home
(b) Address 200 E Orleans St
JUL 19 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16th 1947, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2nd 1946, to June 7th 1947, and that I last saw him alive on June 4th 1947.

Immediate cause of death	Duration
Cerebral arteriosclerosis	2
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H J Sanders M. D.
Address 100 N Wilkens Ave Date signed 7/7/47

X

G53572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 100 B2

G53572
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3008 Foldroft Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No 3008 Foldroft Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mathilde Wegener

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Willy Wegener
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 20 1890

8. AGE: Years	Months	Days	If less than one day
57	3	29	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business Cafeteria

FATHER
12. Name — Wagenfuerer
13. Birthplace Germany

MOTHER
14. Maiden Name Dont Know
15. Birthplace Germany

16 (a) Informant Herbert Wegener
(b) Address 126 N. Linwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 21 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location

18 (a) Funeral director Lellrich Funeral Home
(b) Address 208 Bloom St

19 (a) JUL 19 1947 (Date rec'd by registrar) Huntington Williams, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16th 1947, at 8:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 13, 1947, to July 16, 1947, and that I last saw her alive on July 16, 1947.

Immediate cause of death: Pulmonary embolism — Duration: 1/2 hour
Due to: Thrombo-phlebitis of left lower extremity — 6 days
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature Benj. B. Mora, M.D.
M. D.
Address 448 N. Lafayette Ave. Date signed 7-18-47

X

G53573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

469

Registered No. G53573

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lombard & Greene

(c) Hospital or institution: University Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days

(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Owen Park

(If outside city or town limits, write RURAL and give town)

(d) Street No. Reisterstown R.D. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Alfred W. Young

3 (b) If veteran, name war: —

3 (c) Social Security Account No. —

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Annie Pullman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1885

8. AGE: Years 62 | Months 2 | Days 4 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Textile Worker

11. Industry or business Woolen Mills

FATHER — 12. Name Milton Young

13. Birthplace Md

MOTHER — 14. Maiden Name Mary Murray

15. Birthplace Md

16 (a) Informant Mrs. Anna Young

(b) Address Reisterstown, Md.

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 7/21/47 (month) (day) (year)

(c) Cemetery or crematory Druid Park

Location Baltimore Md

18 (a) Funeral director C. Harris Hess

(b) Address Reisterstown Md

19 JUL 19 1947 (Date received by local registrar) (b) Reisterstown Millers Md

VS. 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 1947, at 3:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 17 1947, to July 18 1947, and that I last saw h. in alive on July 18 1947.

Immediate cause of death	Duration
Carcinoma - head of pancreas -	
Due to complications following cholecystojejunostomy for	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation July 15, 1947

Major findings of operation: Carcinoma, head of pancreas -

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. E. Evans M.D.

Address University Hosp. Date signed 7/28/47 M. D.

G53574 G53574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully recorded. Physicians: please write the correct age in especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2858 Rayner Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Anna E. Mueller

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:

4. Sex: F.
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband ~~or wife~~: Frank Mueller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 14 Dec 1887

8. AGE: Years 59 | Months 7 | Days 3 | If less than one day ... hr. ... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Michael Reuttinger
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Kircher
15. Birthplace Balto. Md.

16 (a) Informant Frank Mueller Jr
(b) Address 2858 Rayner Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/21/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St

19 (a) JUL 19 1947 (Date filed by Registrar) (b) Registrar Washington, M...

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 July 1947 at 10-15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5 July 1947 to 17 July 1947 and that I last saw her alive on 17 July 1947.

Immediate cause of death: Carcinoma of breast with metastasis to liver — Duration:
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation Laparotomy 7-24-47
Major findings of operation: metastasis to liver
of autopsy: Liver metastasis

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Vincent A. Lacarace M. D.
Address Franklin Square Hosp. Date signed 18 July 47

C53575

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. C53575

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette Sts
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2017 W. Lexington St. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Emil Brandt

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Marie C. Brandt
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) October 5, 1891
8. AGE: Years 55 | Months 9 | Days 12 | If less than one day ..... hr. ..... min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Guard
11. Industry or business C. T. Brandt Co.

FATHER
12. Name William Brandt
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna L. Donick
15. Birthplace Maryland

16 (a) Informant Marie C. Brandt
(b) Address 2017 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-19-47 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Maryland

18 (a) Funeral director George L. Schmidt
(b) Address 2101 Pulaski Ave
JUL 19 1947 (Date rec'd by registrar) (by Huntington Williams, Jr.) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17, 1947, at 4:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 26 1947 to July 17 1947 and that I last saw him alive on July 16 1947.

	Duration
Immediate cause of death: Coronary Occlusion	2 hr.
Due to: Coronary Heart Disease	3-4 yrs.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation: —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas Martin, Jr.
Address 933 E. Biddle St. Date signed 7/18/47 M. D.

X

53576 BC# G-77510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 46F

Registered No. C53576

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2919 Baker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gregory T. Larkin

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife ✓

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3rd 1947

8. AGE: Years	Months	Days	If less than one day
	2	15	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Elmer T. Larkin
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Lillian L. Radus
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Elmer T. Larkin
(b) Address 2919 Baker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/21/47 (month) (day) (year)

(c) Cemetery or crematory New Catholic
Location 4300 Old Frederick Rd

18 (a) Funeral director John J. Lawrence & Son
(b) Address 79 Hollins St.

19 (a) JUL 19 1947 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 1947, at 2:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 8 1947 to July 18 1947, and that I last saw h[illegible] alive on July 18 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Pulmonary edema	
Due to Post-operative	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation July 16 - 1947

Major findings of operation: Malignant metastases of liver, origin not known yet.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Asher Freedman M. D.
Address Sinai Hosp Date signed 7-18-47

VS 150

X

G53577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G53577

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3211 LYNDALE AVE.
(c) Hospital or institution:
– NONE –
(d) Length of stay in hospital or inst. (yrs., mos., or days) –
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County –
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3211 LYNDALE AVE.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country – – –

3 (a) FULL NAME MARY A. FLYNN

3 (b) If veteran, name war – – –
3 (c) Social Security Account No. – – –

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: WIDOWED
6 (b) Name of husband or wife: JAMES FLYNN
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 3-7-1862

8. AGE: Years 85 | Months 4 | Days 10 | If less than one day ..... hr. ..... min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business HOME

FATHER
12. Name PATRICK FLYNN
13. Birthplace IRELAND

MOTHER
14. Maiden Name MARY LACEY
15. Birthplace IRELAND

16 (a) Informant ELIZABETH C. FLYNN
(b) Address 3211 LYNDALE AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7-21-47 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location EDMONDSON AVE.

18 (a) Funeral director LILLY & ZEILER INC.
(b) Address 1128 S. WOLFE ST.

19 (a) JUL 19 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 17, 1947 at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-20- 1937 to 7-17- 1947 and that I last saw her alive on 7-17- 1947.

	Duration
Immediate cause of death: Cardio-vascular renal disease	10 yrs
Due to: Generalised Arteriosclerosis	?
Due to:	
Other Conditions: Cerebral Hem. orrhage	1937

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton C. Lacey M. D.
Address 2117 Belair Rd Date signed 7-19-47

X

G53578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164c

G53578

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Annapolis (If outside city or town limits, write RURAL and give town)
(d) Street No. 36 Southgate Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Hutchins Steele

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Gilga G. Steele
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1893

8. AGE: Years	Months	Days	If less than one day
54 57	2	7	hr. min.

9. Birthplace A. A. Co., Md. (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Annapolis Utility Co.

FATHER
12. Name Nevette Steele
13. Birthplace A. A..Co., Md.

MOTHER
14. Maiden Name Anna Brooke
15. Birthplace A. A. Co., Md.

16 (a) Informant Mrs. Gilga G. Steele
(b) Address 36 Southgate Ave., Annapolis, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/21/47 (month) (day) (year)
(c) Cemetery or crematory Arlington National
Location Arlington, Va.

18 (a) Funeral director E. Willis Lamoreau
(b) Address 1003 W. Baltimore St.

JUL 19 1947

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-18-47 19 .., at 6 50 P. M

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of Brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death fill in the following:
(a) Date of injury 7-18-47 at 2 38 P. M.
(b) Where did injury occur? Annapolis, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearms.

23. Signature [signature] M.D. Medical Examiner
Date signed 7-19-47

G53579

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 98

Registered No. G53579

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: [illegible]
(c) Hospital or institution: [illegible]
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2205 Linden Ave (If rural give location)
(e) Citizen of foreign country? [illegible] (Yes or No)
If yes, name country

3 (a) FULL NAME Lena [illegible]

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [illegible]

8. AGE: Years	Months	Days	If less than one day hr.	min.
66	11	6		

9. Birthplace Germany, Not in Maryland (Town, county, and state)

10. Usual Occupation [illegible]

11. Industry or business

FATHER
12. Name Max Summerfield
13. Birthplace Germany

MOTHER
14. Maiden Name Carrie Bower
15. Birthplace [illegible]

16. (a) Informant Fannye Summerfield
(b) Address 2205 Linden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/21/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Harris Goodman & Son
(b) Address 1902 Eutaw Place

JUL 19 1947 (Date received by Registrar) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 1947, at 7:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1947, to July 18 1947, and that I last saw h[illegible] alive on July 18 1947.

Immediate cause of death	Duration
Bronchopneumonia (Postoperative)	1 day
Following operation for Gangrene of L. Hand	
Due to Arteriosclerosis (Symptoms)	2 mos
Other Conditions Anemia (of Unknown origin) (Include pregnancy within 3 months of death)	

Date of operation 7-17-1947

Major findings of operation: Gangrene of hand (L) i amputation (Dr Trimble)

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically. ?

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify home, farm, place)
(e) Means of injury

23. Signature Louis P. Hamburger M. D.
Address 1207 Eutaw Pl Date signed 7-18-47

G53580

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46F

Registered No. G53580

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 913 N Stricker St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 913 N Stricker St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie Young

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Thos. Young

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr)

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name [illegible]
13. Birthplace Md

MOTHER
14. Maiden Name Doris Brown
15. Birthplace Md.

16 (a) Informant [illegible]
(b) Address 1214 Whitelock St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/19/47 (month) (day), (year)
(c) Cemetery or crematory Cedar Grove Cem
Location Balto City, Md.

18 (a) Funeral director Leonard Pierce
(b) Address 2 Lanvale

19 (a) JUL 19 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1947, at 6:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/9/47 19 to 7/16/47 19, and that I last saw h[illegible] alive on 7/16/47

Immediate cause of death Bronchitis
Duration Yrs?
Due to [illegible]

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Ray Ellis M. D.
Address 914 N Stricker St Date signed 7/18/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G53581

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline St.
(c) Hospital or institution: St. Joseph's.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County St. Marys
(c) City or town Great Mills
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? — Yes or No?
If yes, name country

3 (a) **FULL NAME** Joshua L. Dean

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-09-3535

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Lillian M. Dean
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25-1871

8. AGE: Years 76 | Months 3 | Days 23 | If less than one day ... hr. ... min.

9. Birthplace St. Marys Co. Md (Town, county, and state)

10. Usual Occupation Unemployed
11. Industry or business Pensioned by B.T.C.

FATHER
12. Name Joseph Dean
13. Birthplace Maryland

MOTHER
14. Maiden Name Eliza Evans
15. Birthplace Maryland

16 (a) Informant Mrs Sadie Pegg
(b) Address Great Mills, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 20-1947 (month) (day) (year)
(c) Cemetery or crematory Mt Zion
Location St. Marys Co Maryland

18 (a) Funeral director Burgess Funeral Home
(b) Address 3631 Falls Road

19 (a) JUL 19 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-18 1947, at 6 05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-12 1947, to 7-18 1947.
and that I last saw h[illegible] alive on 7-18 1947.

Immediate cause of death Peripheral vascular collapse — Duration
Due to Bronchopneumonia
Due to
Other Conditions Pyelonephritis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify type of place)
(e) Means of injury

23. Signature Robert May M.D.
Address St. Joseph's Hosp Date signed 7-18-47

VS 150

167

G53582

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

G53582 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3016 Du Pont Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3016 Du Pont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert Charles Zimmerman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Mar.

6 (b) Name of husband or wife Nellie L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 19, 1894

8. AGE: Years	Months	Days	If less than one day
52	6	29	hr. min.

9. Birthplace Baltimore, Md. (Town, county and state)

10. Usual Occupation Res & Tavern Bus.

11. Industry or business Prop

FATHER
12. Name Robt Zimmerman
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary S Jonorski
15. Birthplace Germany

16 (a) Informant Mrs Nellie L Zimmerman
(b) Address 3016 Du Pont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-21-47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md

18 (a) Funeral director Lemmon Bros
(b) Address 5005 Reisterstown Rd

JUL 19 1947 (Date rec'd by registrar) (b) Huntington Willis Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1947, at 4:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1947 to July 17 1947 and that I last saw h[illegible] alive on July 16 1947

Immediate cause of death Pulmonary Oedema — Duration

Due to Carcinomatosis of Lung

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature Robert C Mitch M. D.
Address 2457 W Belvedere Date signed 7/18/47

G53583

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G53583

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1249 Orleans St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1249 Orleans St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Josephine Ithida

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Col.	Widow

6 (b) Name of husband or wife Daniel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 28

8. AGE: Years	Months	Days	If less than one day hr.	min
71	7	16		

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Benjamin Diggs
13. Birthplace Md.

MOTHER
14. Maiden Name Harriet
15. Birthplace Md.

16 (a) Informant Gertrude Campbell
(b) Address 405 N 41st St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 17 4 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location

18 (a) Funeral director Wm. Pitt. G Elliott & Son
(b) Address 124 N Caroline St

19 (a) JUL 19 1947 (b) Huntington Williams, Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1947 at 2:30 A M

21. I certify that death occurred on the date above stated, that I attended deceased from June 1 1947 to July 14 1947, and that I last saw her alive on July 13 1947.

Immediate cause of death
Cardiac Failure Renal Complication
Due to Hypertension

Duration

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature H. G. Stewart M. D.
Address 632 W Fayette St Date signed July 18

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

G53584

JL - 112101

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

55E

G53584 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 637 Sterling St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Emmett Bailey

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1893

8. AGE: Years	Months	Days	If less than one day
54	1	29	hr. min.

9. Birthplace ?
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joe Bailey
13. Birthplace Va.

MOTHER
14. Maiden Name Anna Jardon
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof July 19 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A. A. County

18 (a) Funeral director Mrs Robt A. Elliott
(b) Address 1297 N. Carrollton

19 Date JUL 19 1947 by Huntington Hollins M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14, 1947 19 at 5.35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 12 1947 to July 14 1947, and that I last saw h. im alive on July 12 1947.

Immediate cause of death Respiratory failure — Duration

Due to Pulmonary metastases

Due to Carcinoma, abdominal, site undetermined

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Vickers Jr. M.D.
Address Balt. City Hosp. Date signed 16 Jul 47

VS 150

G53585

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 45 B

G53585 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please correct age is especially important. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Redwood & Greene Sts.
(b) Street address [redacted]
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 701 S. Curley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John ~~Maciolek~~ John Maciolek

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Mary Maciolek
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1 1891

8. AGE: Years	Months	Days	If less than one day hr.	min.
56	2	16		

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Tavern Keeper
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Mary Maciolek
(b) Address 701 S Curley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/21/47 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Dundalk Ave

18 (a) Funeral director John J Duda
(b) Address 2824 Hudson St

19 (a) Date received by local registrar JUL 19 1947 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1947, at 5:30 a M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947 to July 17 1947 and that I last saw him alive on 7-16 1947.

Immediate cause of death Respiratory embarrassment — Duration -

Due to Tuberculous Cancer of Tongue

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John H Rowe M. D.
Address Univ. Hosp. Date signed 7-17-47

G53586

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

G53586
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 511 RICHWOOD AVE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 511 RICHWOOD AVE
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) **FULL NAME** HENRY CLAY REISTER JR

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-01-3616

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife LUCY F.
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr) JAN. 14 1902

8. AGE: Years	Months	Days	If less than one day
45	6	4	..... hr. ..... min.

9. Birthplace BALTIMORE
(Town, county, and state)
10. Usual Occupation SALESMAN
11. Industry or business FEUL OIL

FATHER
12. Name HENRY CLAY REISTER
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name SOPHIE NORTH
15. Birthplace BALTIMORE, MD.

16 (a) Informant MRS. LUCY F. REISTER
(b) Address 511 RICHWOOD AVE

17 (a) BURIAL (b) Date thereof 7 21 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LORRAINE
Location BALTIMORE, MD.

18 (a) Funeral director A. R. SLADE
(b) Address 4907 YORK RD.

19 (a) ..... (b) .....
(Filed by registrar)

7 20 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1947 at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1941 to July 19 1947, and that I last saw h alive on July 19 1947.

Immediate cause of death	Duration
CARCINOMA OF STOMACH	2 yrs
Due to	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	

Date of operation July 5 1947
Major findings of operation: Carcinomatosis
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature
M. D.
Address 620 Cathedral St Date signed July 19 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53587 BALTIMORE CITY HEALTH DEPARTMENT X✓ G53587
CERTIFICATE OF DEATH 74a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 das.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 das.

2. USUAL RESIDENCE OF DECEASED: Worcester
(a) State Md. (b) County R.F.D. 2
(c) City or town Berlin, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Levin Parsons

3 (b) If veteran, name war XXX

3 (c) Social Security Account No. none

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-18-1872

8. AGE: Years 75 | Months 4 | Days 1 | If less than one day hr. min.

9. Birthplace Berlin, Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Chas. Parsons
13. Birthplace Maryland

MOTHER
14. Maiden Name Bell Bratton
15. Birthplace Maryland

16 (a) Informant Records
(b) Address U.S. Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 14/47 (month) (day) (year)
(c) Cemetery or crematory Emergreen
Location Berlin, Md.

18 (a) Funeral director John O. Mitchell Funeral
(b) Address 1900 Entaw Place, Huntington Williams, Md.

19 (Date received by registrar) 20 1947 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19, 1947, at 3:45PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-16- 1947, to 7-19 1947, and that I last saw him alive on 7-19- 1947.

Immediate cause of death Chronic Myelogenous Leukemia — Duration Unknown
Due to
Due to
Other Conditions General Arteriosclerosis
Senile Psychoses.
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John B. Sprague M. D.
Address U.S. Marine Hospital, Baltimore, Md. Date signed 7-20-47
X

G53588

BALTIMORE CITY HEALTH DEPARTMENT X G53588 Registered No. 70555

CERTIFICATE OF DEATH 47a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: U S Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 339 days
(e) Length of stay in Baltimore (yrs., mos., or days) 339 days

2. USUAL RESIDENCE OF DECEASED:
(a) State New York (b) County
(c) City or town Woodhaven (If outside city or town limits, write RURAL and give town)
(d) Street No. 8813 85th St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME James Francis Walsh

3 (b) If veteran, name war

3 (c) Social Security Account No. 123-03-2580

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Married

6 (b) Name of husband or wife Margaret Hughs Walsh
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 19, 1905

8. AGE:	Years	Months	Days	If less than one day
	42	5	30 29	hr. min.

9. Birthplace Brooklyn, N.Y. (Town, county, and state)
10. Usual Occupation Able bodied seaman
11. Industry or business Seafarer

FATHER
12. Name Richard A. Walsh
13. Birthplace Brooklyn, N.Y.

MOTHER
14. Maiden Name Mary Murray
15. Birthplace Brooklyn, N.Y.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/22/47 (month) (day) (year)
(c) Cemetery or crematory U.S. NATIONAL
Location PINELAWN, N.Y.

18 (a) Funeral director MARTIN FAHEY & SONS
(b) Address 1827 W. NORTH AVE.

19 (a) 1947 (Date filed by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 19 47, at 4:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 13 19 46, to July 18 19 47 and that I last saw h im alive on July 18 19 47.

Immediate cause of death Squamous cell carcinoma of larynx with extension to neck — Duration: Unknown

~~Disease~~ Pneumonia lobular — Duration: More than 1 wk

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8-22-46

Major findings of operation: Carcinoma of larynx

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wyson Curry M.D.
Wyson Curry, Asst. Surgeon
Address Date signed 7-19-47

G53589

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 170c

Registered No. G53589

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 113-15th Avenue, Brooklyn Park
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME RAYMOND R. SIDES

3 (b) If veteran, name war: World War II N261 30 74

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Helen W. Sides (Nee White)

6 (c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): Aug. 27, 1906

8. AGE: Years 40 | Months 10 | Days 22 | If less than one day ..... hr. ..... min.

9. Birthplace: Concord, N.C. (Town, county, and state)

10. Usual Occupation: Chief Boatswain Mate

11. Industry or business: US NAVY Res. Armory Ft. McHenry Com 6 Norfolk, Va.

FATHER
12. Name: James D. Sides
13. Birthplace: Cabarrus County N.C.

MOTHER
14. Maiden Name: Cora A. Lyles
15. Birthplace: Rowan County N.C.

16 (a) Informant: Mr. Earl Mason
(b) Address: 1301 Maryland Ave. Balto. Md.

17 (a) Shipment (Burial, cremation, or removal) (b) Date thereof July 20 1947 (month) (day) (year)
(c) Cemetery or crematory
Location: Concord, North Carolina

18 (a) Funeral director: Thomas W. Singleton
(b) Glen Burnie, Md.

20 1947 (Date rec'd by registrar) (b) Washington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION 15

20. DATE OF DEATH July 18, 1947, at 11:[illegible] M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull & intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-17-47 at 3:50 P. M.
(b) Where did injury occur? Governor Ritchie Highway at 1st Avenue - A.A. Co.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Auto. skidded into tree (Deceased-driver)

23. Signature [signature] Medical Examiner. M.D.
Date signed 7-18-47

X.

G53590 Kamiecka ✓ G53590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 E. Fairmount ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 ½
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1913 E. Fairmount Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joanna Kamiecki

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Joseph Kamiecki
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Kalinowski
13. Birthplace Poland

MOTHER
14. Maiden Name Josefa Szarczewska
15. Birthplace Poland

16 (a) Informant Joseph Strempek
(b) Address 1913 E. Fairmount ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-21-47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location Balto. County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 47 (Date rec'd by reg.) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1947 at 6 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1947 to July 16 1947 and that I last saw h. alive on July 16 1947.

Immediate cause of death	Duration
Myocardial failure, acute	15 min.
Due to Complete Heart Block	2 hr. min.
Due to Rheumatic Arteriosclerosis	2 yrs.
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George W. LeBoutillier M.D.
Address 601 S. Ellwood Ave. Date signed 7/19/47

VS 150

G53591 BALTIMORE CITY HEALTH DEPARTMENT G53591 Registered No.

CERTIFICATE OF DEATH 49a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The coroner is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 Eutaw Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Typed

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sara Jacobs

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Benson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 12-1869

8. AGE: Years 77 78 | Months 9 | Days 6 | If less than one day hr. min.

9. Birthplace Lith (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Abram Crockin
13. Birthplace Lith

MOTHER
14. Maiden Name Deborah
15. Birthplace Lith

16 (a) Informant Dr Louis K. Jacobs
(b) Address 1700 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-20-47 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel
Location Southern Ave

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Baltimore St

JUL 20 1947 (Date rec'd by registrar)

(b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18th 1947, at 3:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to July 18 1947, and that I last saw h alive on July 18 1947.

Immediate cause of death: Carcinomatosis generalized — Duration
Due to Carcinoma ovary
Due to
Other Conditions advanced arterio-sclerosis
(Include pregnancy within 3 months of death)
Date of operation May 1947
Major findings of operation: Ovarian cyst l. ovary - C A.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis Jacobs
Address 1700 Eutaw Pl. Date signed July 18 1947

VS 150

G53592

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G53592 ✓ 932

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 309 S. Exeter
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31 ✓
(e) Length of stay in Baltimore (yrs., mos., or days) 42

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 309 S. Exeter St.
(If rural give location)
(e) Citizen of foreign country? .....(Yes or No)
If yes, name country .....

3 (a) FULL NAME Santina Principe

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Married

6 (b) Name of husband ~~or wife~~ Salvatore Principe
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) November 1st/84

8. AGE: Years	Months	Days	If less than one day
62	8	13 17	hr. ..... min.

9. Birthplace Casalvecchio di Puglia Italy
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business home

FATHER
12. Name Giovanni G. Tosches
13. Birthplace Italy

MOTHER
14. Maiden Name Luisa Fino
15. Birthplace Italy

16 (a) Informant Salvatore Principe (Husband)
(b) Address 309 S. Exeter St.

17 (a) Burial (b) Date thereof July 22/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Keller Sons
(b) Address 52 [illegible] Harley St.

19 (c) 7-20-1947 (b) [illegible] Williams M.D. Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/18/47 19 ..., at 5 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/4/47 19 to 7/18/47 19 ..., and that I last saw her alive on 7/17/47 19 ...

Immediate cause of death	Duration
Acute Coronary Thrombosis	sudden
Due to Acutey Arthritis	14 days
Due to	.....
Other Conditions Chronic cardio vascular disease, with Hypertrophy	?

(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature [signature] M. D.
Address 1901 Eutaw Pl. Date signed 7/19/47

X

G53593 ✓ G53593

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution: South Balto. Gen. Hosp'l
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 503 S. Mayo St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alberico or Albert Di Stefano

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	215-01-8207

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	widowed

6 (b) Name of husband or wife late Caroline
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21 1883

8. AGE: Years	Months	Days	If less than one day
64	1	28	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER 12. Name Ermindo Di Stefano
13. Birthplace Italy

MOTHER 14. Maiden Name Antonia Iessi
15. Birthplace Italy

16 (a) Informant Beatrice Cook
(b) Address 503 S Mayo St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 21/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location
18 (a) Funeral director Frank Dellas Noe
(b) Address 52 N. Morley St.
19 (a) (Date rec'd by registrar) (b) Huntington Willis, Registrar

20 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1947, at 5:25 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 18 1947, to July 19 1947, and that I last saw h[illegible] alive on July 19 1947.

Immediate cause of death	Duration
Pneumonia, bilateral	3 days
Due to Exfoliative dermatitis, severe, cause undetermined	1 week
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Pillon M. D.
Address South Balto Gen Hosp Date signed July 19

G53594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G53594

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 147 N Decker Av
(c) Hospital or institution:
b
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 147 N. Decker Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Jennie) Johanna Hurka

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife. Frank J. Hurka

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1878

8. AGE: Years 69 | Months | Days 13 | If less than one day hr. min.

9. Birthplace Moravia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Frank Hrubes
13. Birthplace Moravia

MOTHER
14. Maiden Name Johanna Kiva
15. Birthplace Moravia

16 (a) Informant Josephine Zahner
(b) Address 1474 Decker Ave

17 (a) Burial (b) Date thereof 7-21-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Frank Brach & Son
(b) Address 900 N. Chester st

JUL 21 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 1947, at 1:A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to July 18 1947 and that I last saw h alive on July 18 1947.

Immediate cause of death Coronary Thrombosis — Duration 7/17/47

Due to Chr. Myocarditis — 6/1/47

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Rowan M.D.
Address 801 N Eutaw St Date signed 7/18/47

X

G53595 4

BALTIMORE CITY HEALTH DEPARTMENT X ✓ Registered No. G53595

CERTIFICATE OF DEATH 137a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Cecil
(c) City or town Elkton
(If outside city or town limits, write RURAL and give town)
(d) Street No. 223 E. Main St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Gee

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years: 74 | Months | Days | If less than one day: hr. min.

9. Birthplace England (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Harry Gee
13. Birthplace England

MOTHER
14. Maiden Name Mary Driver
15. Birthplace England

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 23 47 (month) (day) (year)
(c) Cemetery or [redacted] Philadelphia
Location Philadelphia, Pa.

18 (a) Funeral director H. W. Pippin & Son
(b) Address Elkton Md.

JUL 21 1947 (b) [illegible] Washington Williams M.D.
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1947, at 3 20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1947, to July 20 1947, and that I last saw him alive on July 19 1947.

Immediate cause of death Uremia — Duration 1½ - 2 Mos

Due to Chronic urinary obstruction — 2-3 yrs

Due to Benign prostatic hypertrophy — 2-3 yrs

Other Conditions Cystitis

(Include pregnancy within three months of death)

Date of operation 7/9/47

Major findings of operation Benign prostatic hypertrophy

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edgar Young Jr. M.D.
Address University Hosp Date signed July 21, 1947

X

G53596 B.C.#S. 89651

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 168

Registered No. G53596 (over)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Found Strangulated
(a) Baltimore City, Maryland
(b) Street address 3rd Sta.
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County HOWARD
(c) City or town GLENELG
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Hoschall (HOSCHALL)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Infant

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? JULY 2, 1947

8. AGE: Years	Months	Days	If less than one day
—	—	?	newborn hr. 15 min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)

10. Usual Occupation INFANT

11. Industry or business —

FATHER
12. Name UNKNOWN
13. Birthplace —

MOTHER
14. Maiden Name THELMA LOUISE HOSCHALL
15. Birthplace NOT STATED

16 (a) Informant STATE'S ATTORNEY'S OFFICE
(b) Address BALTIMORE, MD.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Loc Johns Hopkins Medical Schoo JUL 18 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUL 21 1947 M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9 1947, at 6:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Strangulation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury found 7-9-47 at 6 A M.
(b) Where did injury occur? Found: Glenelg Boonsboro Rd (Lodge)
(c) Did injury occur at home, on farm, industrial place, in public place? Found: Public Place While at work? no
(d) Means of injury Strangulation by ligature around neck

23. Signature Elbridge G. Merrill M.D.
Medical Examiner
Date signed 7-9-47

653597

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 653597

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Sorrento Ave
(c) Hospital or institution: Colonial Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1533 Poplar Grove St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles R. (Sr.) Weir

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: late Lydia E. Bonnschener

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1869

8. AGE: Years 78 | Months 2 | Days 7 | If less than one day hr. min.

9. Birthplace Penna.
(Town, county and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. J. C. Burdette
(b) Address 2916 W. Mosher St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/21/47 (month) (day) (year)

(c) Cemetery or crematory Lorraine Park
Location Woodlawn Md

18 (a) Funeral director Harry H. Wiltze
(b) Address 4401 Edmondson Ave

19 (a) Date received by Registrar JUL 21 1947 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947 to July 18 1947 and that I last saw him alive on July 18 1947.

Immediate cause of death: Cerebral Hemorrhage — Duration: 4 days

Due to: Hypertension

Due to: Arteriosclerosis

Other Conditions: None

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Chas. Martin Jr. M.D.

Address 1933 W. Balto St Date signed 7/19/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53598

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 20E

Registered No. G53598

CM. 112208

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 207 N. Pine ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Warren, George (Last name Warren)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Catherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 9 - 1902

8. AGE: Years	Months	Days	If less than one day
44	11	8	hr. min.

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Addison Warren
13. Birthplace VA.

MOTHER
14. Maiden Name Maggie Adams
15. Birthplace VA.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 21-1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location Balto

18 (a) Funeral director Pierce E. Williams
(b) Address 1515 McElderry St

19 (a) JUL 21 1947 (Registrar's signature) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 - 1947, at 9.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 16 - 1947, to July 17 - 1947, and that I last saw h[illegible] alive on July 17 - 1947.

Immediate cause of death	Duration
Cardiac Failure	
Due to Syphilitic Heart Disease.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Syphilitic Aortitis + Aortic Valvulitis: Cardiac Hypertrophy + Dilatation.

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. R. Amberson M. D.
Address Balto City Hosp. Date signed 7-18-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C53599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C53599

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3401 Parklawn Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3401 Parklawn Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN PETER NEELS, sr.

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Catherine Neels
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1871

8. AGE: Years	Months	Days	If less than one day
76	1	4	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name ? Neels
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline ?
15. Birthplace Germany

16 (a) Informant Miss Rolena Neels
(b) Address 3401 Parklawn Avenue

17 (a) Burial (b) Date thereof 7/21/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

19 JUL 21 1947 (Signature) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1947, at 6.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1938 to July 1947 and that I last saw h. alive on 7-16 1947.

Immediate cause of death	Duration
acute cardiac failure	1 hr.
Due to Chronic myocarditis & coronary sclerosis	5 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Watson Moore M. D.
Address 3105 Belair Rd. Date signed 7-16-47

X

G53600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

Registered No. G53600

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 576 Chapel Gate Lane
(c) Hospital or institution: Venetian Lodge
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 MOS
(e) Length of stay in Baltimore (yrs., mos., or days) 10 MOS

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna. (b) County
(c) City or town Philadelphia
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis Paullis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Mary M. Paullis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 16, 1871

8. AGE: Years	Months	Days	If less than one day
75	7	3	hr. min.

9. Birthplace Litchfield, Illinois (Town, county, and state)
10. Usual Occupation Supt of printing B. & O. R.R.
11. Industry or business Balto & Ohio Railroad

FATHER
12. Name Charles Paullis
13. Birthplace Prussia

MOTHER
14. Maiden Name Madeline Pfohl
15. Birthplace Unknown

16 (a) Informant Mrs. Charles H. Kinnane
(b) Address 2417 Poplar Rd - Penna

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 22-'47 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel Cem.
Location Chicago, Illinois

18 (a) Funeral director Delsworth Arnsparger
(b) Address 3911 Liberty Heights Ave.

JUL 21 1947 (Date received by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/19 1947 at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/18 1947 to 7/19 1947.
and that I last saw X alive on 7/19 1947.

Immediate cause of death: Coronary Occlusion — Duration 2 days
Due to Arteriosclerosis — ?
Due to
Other Conditions Senile Dementia — 10/18/47

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Damian P. Alagna M. D.
Address 3316 Fredericks Ave (Date signed)

VS 150

C53601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V186A

Registered No. C53601

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Dukeland & Raynor
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
8-16
(d) Street No. 1509 N. Caroline St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Robert G. Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of ~~husband~~ or wife Mary Lavinia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16, 1859

8. AGE: Years	Months	Days	If less than one day
88	2	3	hr. min.

9. Birthplace Pittston Pa.
(Town, county, and state)
10. Usual Occupation Physician
11. Industry or business

FATHER
12. Name James Davis
13. Birthplace Wales

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace "

16 (a) Informant Charles D. Davis
(b) Address 174 Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 21 1947 (month) (day) (year)
(c) Cemetery or crematory Dashwood
Location Balto. Co Md

18 (a) Funeral director Williams Cook Co
(b) Address 1317 St. Paul St

19 (a) JUL 21 1947 (Date rec'd by registrar) (b) Registrar for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 July 1947, at 8:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 15 July 1947 to 19 July 1947, and that I last saw him alive on 19 July 1947.

Immediate cause of death Cerebral Failure

Due to Arteriosclerosis, Cardio-vascular Disease

Due to

Other Conditions Fracture of left hip

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
4 days.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 15 July 1947 at 3 P.M.
(c) Where did injury occur? Baltimore (City or town) Md. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fell from bed

23. Signature Hiram M. Cheshire M.D.
Address W. Balto. Gen. Hosp. Date signed 19 July 1947

Howard J. Tenebaum M.D.

VS 150

Dr Schonfield 2301 Annapolis Road

G53602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83A

G53602 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2435 Smith Avenue (Lakeland)
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (27)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2435 Smith Avenue
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Germany

3 (a) FULL NAME OTTO FAHL

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 216-07-6539

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 30, 1881

8. AGE: Years 66 | Months 5 | Days 19 20 | If less than one day ..... hr. ..... min.

9. Birthplace Bochum, Germany
(Town, county, and state)
10. Usual Occupation Cook & Handyman
11. Industry or business Morrell Park Salad Co.

FATHER
12. Name UNKNOWN
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Harriet Miles
(b) Address 2435 Smith Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 22, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Maryland

18 (a) Funeral director William Cook, Inc.,
(b) Address 1217 St. Paul Street

19 (a) July 21 1947 Huntington Williams M.D.
(Date received by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1947 at 10 M

21. I certify that death occurred on the date above stated, that I attended deceased from July 1 1947 to July 19 1947, and that I last saw h alive on July 18 1947

Immediate cause of death: Cerebral Hemmorhage — Duration 18 days

Due to:

Due to: Hypertension —

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Schonfield
Address 2301 Annapolis Date signed 7/20/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G53603

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST.
(c) Hospital or institution: ST. JOSEPH'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 419 E. PRESTON ST. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME CRAIG, JOHN H.

3 (b) If veteran, name war: NONE

3 (c) Social Security Account No. 217-01-0104

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: VIRGINIA CRAIG
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/7/84

8. AGE: Years 62 | Months 9/10 | Days 12 | If less than one day hr. min.

9. Birthplace WINCHESTER, VIRGINIA (Town, county, and state)

10. Usual Occupation STEEL FABRICATOR

11. Industry or business MARYLAND DRY DOCKS

FATHER
12. Name HIRAM CRAIG
13. Birthplace VA.

MOTHER
14. Maiden Name ANNE SMITH
15. Birthplace VA.

16 (a) Informant MRS. VIRGINIA CRAIG
(b) Address 419 E. PRESTON ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JULY 23 1937 (month) (day) (year)
(c) Cemetery or crematory PARKWOOD
Location PARKVILLE, MD

18 (a) Funeral director WILLIAM COOK, INC.
(b) Address 1217 ST. PAUL ST.

19 (a) [illegible] (b) [illegible] Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/19 1937, at 12 55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/16 1937, to 7/19 1937 and that I last saw h[illegible]M alive on 7/19 1937.

	Duration
Immediate cause of death: CARDIAC FAILURE	
Due to: CARDIAC INFARCTION	3 DAYS
Due to: CORONARY THROMBOSIS	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Ruptured left ventricle
At
(Ruptured left ventricle Cardiac tamponade)
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry J. Houser M.D.
Address St. Joseph's Hosp. Date signed 7/19/37

VS 150

G53604

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G53604 Registered No.

CWK-111832

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 47 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 20 E. Lafayette Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Zents

3 (b) If veteran, name war: W
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife: ~~Raymond~~ Charles (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2-1900

8. AGE: Years	Months	Days	If less than one day
47	2	16	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name George W. Bailey
13. Birthplace Maryland
14. Maiden Name Elizabeth Sadoski
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JULY 22 1947 (month) (day) (year)
(c) Cemetery or crematory WOODLAWN
Location WOODLAWN, Md.

18 (a) Funeral director WILLIAM COOK, INC
(b) Address 1217 ST. PAUL ST.

JUL 21 1947 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH July 18 19 47, at 2:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 19 47, to July 18 19 47, and that I last saw her alive on July 18 1947.

Immediate cause of death	Duration
Epidermoid Carcinoma of uterine cervix	1 yr.
Due to	
Due to	
Other Conditions Minimal Tuberculosis of both lungs (Include pregnancy within 3 months of death)	3 mos.

Date of operation
Major findings of operation:
of autopsy: see above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph J. Bowen Jr. M. D.
Address Balto. City Hosp. Date signed 7-19-47

X

G53605

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1319

Registered No. G53605

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: DOA
(a) Baltimore City, Maryland
(b) Street address 1414 W. Franklin St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1414 W. Franklin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Blanche V. Talbot

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4-1887

8. AGE: Years	Months	Days	If less than one day
60	—	16	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Joseph Talbot
13. Birthplace Md

MOTHER
14. Maiden Name Sarah Sewell
15. Birthplace Md

16 (a) Informant Charles Talbot
(b) Address 1414 W. Franklin St

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 7-23-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location City

18 (a) Funeral director Samuel W. Sullivan, Jr.
(b) Address 1011 N. Arlington Ave

19 (a) JUL 21 1947 (Rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/20 1947 at 8:30 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Renal Renal Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. C. Sabrosky M.D.
Medical Examiner.
Date signed 7/20/47

G53606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

G53606
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 11 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 418 George St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Anna Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fmak	Black	single

6 (b) Name of husband or wife

6 (c) If alive, give age [redacted] years

7. Birth date of deceased (mo., day, yr.) Jan. 1897

8. AGE: Years	Months	Days	If less than one day
50 [redacted]	6	?	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Landlady
11. Industry or business -

FATHER
12. Name John Davis
13. Birthplace North Carolina

MOTHER
14. Maiden Name Caroline Smith
15. Birthplace North Carolina.

16 (a) Informant Carrie Hixon
(b) Address 524 W. Saratoga St

17 (a) B (Burial, cremation, or removal) (b) Date thereof 7-22-47 (month) (day) (year)
(c) Cemetery or crematory
Location Chadbourn N. C.

18 (a) Funeral director Samuel W. Sullivan Jr
(b) Address 1811 N. Arlington Ave

19 (a) Date received by local registrar JUL 21 1947 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 1947 at 5:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 7 1947 to July 18 1947 and that I last saw her alive on July 18 1947

Immediate cause of death Cerebral Hemiplegia — Duration

Due to Hypertension

Due to Arterio sclerotic Heart Disease

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature N. B. Scott M. D.
Address Mercy Hospital Date signed 7/18/47

G53607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G53607
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4103 Penhurst Ave
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 63 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 10
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4103 Penhurst Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Reed Folger

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Marguerite M. Folger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 25 1873

8. AGE: Years	Months	Days	If less than one day
73	10	24	hr. min.

9. Birthplace Norfolk Va
(Town, county, and state)
10. Usual Occupation Retired Jury Clerk
11. Industry or business Supreme Court of Balto City

FATHER
12. Name Ellery H. Folger
13. Birthplace Nantucket Mass

MOTHER
14. Maiden Name Sarah Reed
15. Birthplace Norfolk Va

16 (a) Informant Virginia M. Folger
(b) Address 4103 Penhurst Ave

17 (a) Burial (b) Date thereof July 22 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Harry N. Arnascost
(b) Address 4204 Edgewood Ave

19 JUL 21 1947 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1947, at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 8 1947 to July 19 1947, and that I last saw h alive on July 18 1947.

Immediate cause of death	Duration
Chronic Nephritis	1 yr
Due to Arteriosclerosis	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 3403 Sam-Bel Date signed 7/19/47

G53608

CM. 111836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 164E

Registered No. G53608

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 16 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 213 Dickman ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sumick Mildred or Milka Simich

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Adam Sumick (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? - ? - ?

8. AGE: Years	Months	Days	If less than one day
55 ?			hr. min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace Austria

MOTHER
14. Maiden Name ?
15. Birthplace Austria

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 21-47 (month) (day) (year)
(c) Cemetery or crematory Holy Trinity Russian
Location Stony Run, Md

18 (a) Funeral director John G. Gisblanyckas Jr.
(b) Address 1423 S. Paca St.

JUL 21 1947 (Date received by Registrar) (b) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 - 1947, at 9.50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July - 1 1947 to July -17 1947, and that I last saw her alive on July -17 1947.

Immediate cause of death	Duration
1. Skull Fracture	Instant
2. Bilateral Hemothorax	2 hrs
3. Laceration of liver, with Retro-peritoneum	
4. Fracture Sternum & Lower Jaw	
Due to Face from 3rd & 5 Story Window	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
(over)
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide SUICIDE Accident
(b) Date of occurrence 7/17/47 at 7.22 P.M.
(c) Where did injury occur? Baltimore Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Balt City Hosp. While at work? No (Specify type of place)
(e) Means of injury JUMP Face from Window
23. Signature J. S. Lazarato
Address Baltimore City Hosp. Date signed 7/18/47 M.D.

To Be Approved By Medical Examiner for D. L. C. 4 Holmes T. Mallory M.D.

G53609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G53609

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1206 Cleveland St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 Cleveland St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA MARGARET BECKER

3 (b) If veteran, name war: -
3 (c) Social Security Account No. -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife: -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3, 1900

8. AGE: Years	Months	Days	If less than one day
47	0 1	16	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business A. & P. Co.

FATHER
12. Name Henry Becker
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mary E. Kirschner
15. Birthplace Balto., Md.

16 (a) Informant Mrs. J. R. Allen
(b) Address 1206 Celveland St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7.22.47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 JUL 21 1947 (Date rec'd by Registrar) (b) Function for Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19, 1947 at 12:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-10 1945 to 7-19 1947. and that I last saw h alive on 7-19 1947.

Immediate cause of death	Duration
a Cute Cardiac Failure	1 da
Due to Coronary Occl. Heart	
c Arteriosclerosis	Yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hugh E. Lawlicks M. D.
Address 6794 Wash Blvd Date signed 7/20/47

C53610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. C53610

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey St.
(c) Hospital or institution: 18
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 27 N. Carey St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Justus

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	divorced

6 (b) Name of husband or wife -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1865

8. AGE: Years	Months	Days	If less than one day
81	9	15	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation -

11. Industry or business -

FATHER
12. Name Henry Wessel
13. Birthplace Germany

MOTHER
14. Maiden Name Henrietta Ei
15. Birthplace Germany

16 (a) Informant Mr. Elmer Justus
(b) Address 521 Normandy Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 21, 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JUL 21 1947 (b) Huntington Williamsburg, Md.
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 1947, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 18 1947, to July 18 1947, and that I last saw h[illegible] alive on July 18 1947.

Immediate cause of death	Duration
Carcinoma of Stomach	6 mos
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Milton E. Solomon, M.D.
Address 129 S. Bway Date signed 7/18/47

G53611

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1949

Registered No. G53611

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Charles & Read Sts.
(c) Hospital or institution: ---------- 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ----------
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. Charles and Read Sts.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ----------

3 (a) FULL NAME J. Paul Lartz

3 (b) If veteran, name war	3 (c) Social Security Account No.
----------	----------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Dolores Stack
6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
About 55	---	---	---- hr. ---- min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Tax Accountant
11. Industry or business Safe Deposit & Trust C

FATHER
12. Name William H. Lantz
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary T. Knauf
15. Birthplace Maryland

16 (a) Informant Mrs. Dolores S. Lantz
(b) Address Latrobe Apts.

17 (a) Burial (b) Date thereof 7/22/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director H. W. Meades and Son
(b) Address 805 N. Calvert St.

19 JUL 21 1947 (b) Registrar
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19th 1947, at 12:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1st 1947, to July 19th 1947, and that I last saw h--- alive on July 19 1947.

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Cerebral Hemorrhage	1 year
Due to	
Due to	
Other Conditions Ca	

(Include pregnancy within 3 months of death)
Date of operation Ca
Major findings of operations: Ca
of autopsy: Ca

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. A. Shotland M. D.
Address 1306 Calvert St Date signed July 20, 1947

G53612

BALTIMORE CITY HEALTH DEPARTMENT

MILLAR CERTIFICATE OF DEATH 139B

Registered No. G53612

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 412 Northway (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Grace Thomas Millar

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) — 1879

8. AGE: Years 68 Months — Days — If less than one day — hr. — min.

9. Birthplace Baltimore Md. (Town, county, and State)

10. Usual Occupation Retired Practical Nurse

11. Industry or business —

FATHER
12. Name James Millar
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Early (EARLY)
15. Birthplace Maryland

16 (a) Informant Mrs. Herbert Millar Sr
(b) Address 412 Northway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/21/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 111 N. Calvert St.

19 (a) — (Date rec'd by registrar) JUL 21 1947

Huntington Millar Maryland

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1947, at 9.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 3 1947 to July 15 1947, and that I last saw h[illegible] alive on July 15 1947.

Immediate cause of death: Cerebral hemorrhage

Duration: 1 Day

Due to: —

Due to: —

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation July 17 1947

Major findings of operation: Parietal Rupture

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

83. Signature Samuel S Ashdal M. D.
Address Union Memorial Hosp Date signed July 15

G53613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G53613 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3004 Rosalind Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3004 Rosalind Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dora Gordon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Hyman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 71 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Elega
13. Birthplace Russia

MOTHER
14. Maiden Name Minnie
15. Birthplace Russia

16 (a) Informant Le Gordon
(b) Address 3824 Roland View Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-21-47 (month) (day) (year)

(c) Cemetery or crematory
Location Hebrew Herzog Cem

18 (a) Funeral director Jack Levin Inc
(b) Address 1429 E Balto St

19 JUL 21 1947 (Date rec'd by registrar) Huntington Williams (Signature of registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-20-1947 at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1945 to July 20 1947. and that I last saw h[illegible] alive on July 20 1947.

Immediate cause of death Coronary Thrombosis

Due to Arteriosclerosis Hypertension

Due to Cardio-vascular disease

Other Conditions Chronic Cholecystitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry A Irvine M. D.
Address 3643 Keystone Pl Date signed 7/24/47
Office 118 Bryan with X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53614

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94 A

Registered No. G53614

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2627 Hudson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2627 Hudson St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Stanislaw F Bartkowiak

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Mary Bartkowiak
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
72			hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Stationary engineer
11. Industry or business

FATHER
12. Name Jozef Bartkowiak
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace Germany

16 (a) Informant Mary Bartkowiak
(b) Address 2627 Hudson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/23/47 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Dundalk Ave

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St

19 (a) JUL 21 1947 (Date rec'd by registrar) Huntington Willia... M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/20/47 at 10:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/11 19 47 to 7/20 19 47 and that I last saw h[illegible] alive on 7/19 19 47

Immediate cause of death	Duration
Coronary Thrum	14d
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr Stella F. Kondrowski M. D.
Address 1015 Fountain Ave Date signed

V S 150

X

B114

G53615 BALTIMORE CITY HEALTH DEPARTMENT G53615

Tasco CERTIFICATE OF DEATH 95c Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1525 E Preston St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1525 E Preston St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Estella Tasco

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	C.	Widow

6 (b) Name of husband or wife Melmon Tasco
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22 1887

8. AGE: Years	Months	Days	If less than one day
60	2	24	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Francis Brown
13. Birthplace Md

MOTHER
14. Maiden Name Ellen Osborne
15. Birthplace Md

16 (a) Informant Alma Tasco Catlin
(b) Address 1612 E Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 24 47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A.A. County Md

18 (a) Funeral director Mrs Robt G. Stewart
(b) Address 1124 N Caroline St.

19 (a) [illegible] record by reg[illegible] July 21 1947 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/16 1947 at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/15 1947 to 7/16 1947 and that I last saw h. alive on 7/15 1947.

Immediate cause of death	Duration
Cerebral Hemmorrhage	11 days
Due to Hypertension.	
Due to Arthrisclerosis.	
Other Conditions Cardiac Hypertrophy and Hypertension. (Include pregnancy within 3 months of death)	Complete

Date of operation none
Major findings of operation:
of autopsy none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Ralph J. Yeomans M. D.
Address 1429 E Monument Date signed 7/21/47

83A

C53616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 55E

Registered No. C53616

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3501 E. Pratt St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3501 E. Pratt St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Theodore Fratta

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	215-01-4323

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	Married

6 (b) Name of husband or wife Erminia Fratta
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20 1885

8. AGE: Years	Months	Days	If less than one day
62		28	hr. min.

9. Birthplace Casalvecchio di Puglia-Foggia-Ita.
(Town, county, and state)
10. Usual Occupation Costruction Forman
11. Industry or business

FATHER
12. Name Raffaele Fratta
13. Birthplace Italy

MOTHER
14. Maiden Name Rosina Venditti
15. Birthplace Italy

16 (a) Informant Erminia Fratta
(b) Address 3501 E. PRatt St.

17 (a) Burial (b) Date thereof July 22/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Wolfe St.

19 (a) JUL 21 1947 (b) Huntington Williamson, Md.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1947, at P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 19 to 19, and that I last saw h[illegible] alive on 7/19 1947.

Immediate cause of death Septic Pneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration 1 week

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank L. Meaney M. D.
Address 333 S. Ea[illegible] Date signed 7/21/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 83 A

Registered No. G53617

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 926 S. Bouldin St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 926 S. Bouldin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Kordek

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Frank

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name
13. Birthplace Poland

MOTHER
14. Maiden Name
15. Birthplace Poland

16 (a) Informant Marie Persan
(b) Address 926 S. Bouldin St

17 (a) Burial (b) Date thereof 7-22-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto. Co.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern ave.

19 JUL 21 1947 Huntington Williams M.D.
(Local registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 1947, at 3 20 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 27 1947, to July 17 1947, and that I last saw h-- alive on July 17 1947.

Immediate cause of death	Duration
Hemorrhage into cerebrum,	21 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Milton L. Solomon
Address 29 S. Broadway Date signed 7/18/47 M.D.

X

G53618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

G53618
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rutland & Monument
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 wk
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Middle River
(If outside city or town limits, write RURAL and give town)
(d) Street No. Box 335 Rt 13 Balto 21
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martin Eichorn (Eichhorn)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, divorced. Married

6 (b) Name of husband or wife Dora

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-14-1876

8. AGE: Years 70 73 | Months 8 | Days 5 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Jorge Eichhorn
13. Birthplace Germany

MOTHER 14. Maiden Name Eva. Kleckindienst
15. Birthplace Germany.

16 (a) Informant Dora Eichhorn
(b) Address Middle River Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 23 47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto Co. Md

18 (a) Funeral director J. Bruchenbrecher
(b) Address 4007 Eastern Ave Rd

19 (a) JUL 21 1947 (Date rec'd by registrar) (b) Huntington Nitchie M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/19 1947, at 12.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/17 1947 to 7/19 1947 and that I last saw him alive on 7/19 1947

Immediate cause of death Carcinomatosis — Duration 4 mo
Due to Carcinoma of Cardia of Stomach
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: CA. Stomach & metastases

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. A. Eichenberg M.D.
M. D.
Address Sinai Hosp Date signed 7/19/47

X

G53619

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

B'ham-81780

153

G53619

Registered No.

Every item of information should be carefully supplied. The cause of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK. Especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1608- N. Gilmor St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward WILLIAMSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/21/47

8. AGE: Years	Months	Days	If less than one day
	1	29	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Hezekiah Williamson
13. Birthplace N.C.

MOTHER
14. Maiden Name Eloise White
15. Birthplace NC.

16 (a) Informant Hezekiah Williamson
(b) Address 1608- N. Gilmor St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 7-21-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. 60.

18 (a) Funeral director Samuel N. Sullivan Jr.
(b) Address 1011 N. Eutaw St.

19 (a) JUL 21 1947 (Date rec'd by registrar) Washington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21, 1947, at 8.40 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Impetigo

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 7/21/47

G53620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G53620

ST. 112190

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2007 N. Bentalou St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER SCOTT OLEWINE

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	578-12-7550

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Edith May Olewine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8th 1869

8. AGE: Years	Months	Days	If less than one day
78	0	10	hr. min.

9. Birthplace Pa. (Harrisburg)
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name ? Olewine
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/22/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date received by Local Registrar JUL 21 1947 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18th 1947, at 4.15 A.M. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 15/ 1947 to July 18 1947 and that I last saw h in alive on July 18 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	3 hrs
Due to [redacted]	7
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature E. Coleman Jr. M.D.
Address B.M. City Hosp. Date signed 7/19/47

G53621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G53621

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3033 Pinewood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3033 Pinewood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eulah C. Hurlock

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Frank A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 16-1888

8. AGE: Years	Months	Days	If less than one day
59	4	2	hr. min.

9. Birthplace James Island Md.
(Town, county and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Augustus F. Geoghegan
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Maguire
15. Birthplace Md.

16 (a) Informant Mr. Frank A. Hurlock
(b) Address 3033 Pinewood Ave

17 (a) Burial (b) Date thereof 7-22-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland
Location Balto

18 (a) Funeral director Leonard J. Cusick
(b) Address 5395 Harford Ave

19 (a) JUL 21 1947 (b) Turnbull-Williams, Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/18 1947 at 11:20 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive C V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 7/19/47

G53622

Dr. White
5214 Harford Road

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1947

G53622
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2113 Hamilton Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7/16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2113 Hamilton Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Flanigan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Annie R.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1891

8. AGE: Years	Months	Days	If less than one day
55	9	6	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Flanigan
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Edel
15. Birthplace Md.

16 (a) Informant Mrs. Annie R. Flanigan
(b) Address 2113 Hamilton Avenue

17 (a) Burial (b) Date thereof 7/22/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) JUL 21 1947 (b)
(Date rec'd by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19, 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1946 to July 19 1947 and that I last saw him alive on July 19 1947.

Immediate cause of death | Duration
Hypostatic Pneumonia | 5 days
Due to PRIMARY CARCINOMA OF LUNGS. | 4 mos.
Due to GENERALized Metastatic. |
Other Conditions CARCINOMA. |

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury

23. Signature James E. White
Address 5214 Harford Rd Date signed July 24, 47.

Huntington Hillcrest, Md.

G53623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G53623 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3007 SOUTHERN AVE
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 ?
(e) Length of stay in Baltimore (yrs., mos., or days) 75 HRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3007 SOUTHERN AVE (If rural give location)
(e) Citizen of foreign country? — NO (Yes or No)
If yes, name country —

3 (a) FULL NAME PAULINE (NMI) WIELAND

3 (b) If veteran, name war: No
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	WIDOWED

6 (b) Name of husband or wife JOHN WIELAND, SR.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 28, 1868.

8. AGE: Years	Months	Days	If less than one day
78	8	21	hr. min.

9. Birthplace Wash. D.C. (Town, county, and state)
10. Usual Occupation None.
11. Industry or business

FATHER
12. Name Joseph Wells.
13. Birthplace Va.

MOTHER
14. Maiden Name Ellana Galloway Benson.
15. Birthplace Balto.

16 (a) Informant Edith E. Olson
(b) Address 3007 Southern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-23-47 (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director Leonard J. Poole
(b) Address 5 E. S. Harford Rd.

19 (a) JUL 21 1947 (Date rec'd by registrar) (b) Huntington Williamson, M.D. Address

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 19 1947, at 9:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from JULY 19 1947 to JULY 19 1947 and that I last saw h— alive on — 19—.

Immediate cause of death: MYOCARDIAL FAILURE — Duration 5 MIN.
Due to ARTERIOSCLEROTIC C-V-D — 2
Due to —
Other Conditions SENILITY
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —
23. Signature John M. Scott M. D.
Address 8 Leonard Rd #10 Date signed JULY 19

VS 150

G53624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G53621

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 929 Hilmer Ct
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 929 Hilmer Ct
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JULIUS G GALLAWAY JR.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex MALE | 5. Color or race COLORED | 6 (a) Single, married, widowed, or divorced. SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 4, 1884

8. AGE: Years 62 | Months 9 | Days 14 | If less than one day hr. min.

9. Birthplace VIRGINIA (Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business

FATHER 12. Name JULIUS GALLAWAY

13. Birthplace N. C.

MOTHER 14. Maiden Name AMANDA TUCKER

15. Birthplace N. C.

16 (a) Informant WM A GALLAWAY Wife

(b) Address 1309 MONTELLO AVE DC

17 (a) Burial (b) Date thereof 7/21/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Baltimore

18 (a) Funeral director William A. Jackson

(b) Address 916 Pennsylvania Ave

(c) (Date rec'd) JUL 21 1947 (b) Washington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 1947 at 7A. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 4 1947 to July 16 1947 and that I last saw him alive on 19

Immediate cause of death Pulmonary TBC

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
14 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature
Address Date signed 7/21/47

G53625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G53625

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1651 Montpelier St
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1751 Montpelier
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Caroline Agnew

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widowed

6 (b) Name of husband or wife John Agnew
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) jan 12 1856

8. AGE: Years	Months	Days	If less than one day
91	6	9	hr. min.

9. Birthplace Snow Hill Md (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Dont Know
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace Don't Know

16 (a) Informant Mrs Stephen Krant
(b) Address 1751 Montpelier St

17 (a) Remove (Burial, cremation, or removal) (b) Date thereof Jul 24 (month) (day) (year)
(c) Cemetery or crematory Methodist Cem
Location Snow Hill Md

18 (a) Funeral director Clay Dennis
(b) Address Snow Hill

19 (a) JUL 21 1947 (Date rec'd by registrar) Huntington Williams, M. D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1947, at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1947, to July 21 1947, and that I last saw h. alive on July 20 1947

Immediate cause of death Oedema of Lungs — Duration 2 Days
Due to
Due to
Other Conditions Generalized arteriosclerosis 10 yrs
Chronic Myocarditis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. L. Leichtenberg M. D.
Address 708 E. North Ave Date signed 7/21/47

111 c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53626 EVA K. KLAUENBERG

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117a

Registered No. G53626

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5508 Hilltop Ave
(c) Hospital or institution: St Joseph Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No 5508 Hilltop Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME KLAUENBERG, EVA K.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife JOHN H. T. KLAUENBERG
6 (c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.) 3/16/1874

8. AGE: Years	Months	Days	If less than one day
73.	5	6	....hr. ....min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER
12. Name Jacob Staas
13. Birthplace Germany

MOTHER
14. Maiden Name Juliana Steck
15. Birthplace Germany

16 (a) Informant John H Klauenberg
(b) Address 5508 Hilltop Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 24 (month) (day) (year)
(c) Cemetery or crematory Balto Nat Cem
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) JUL 21 1947 Registered by Registrar Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1947, at 2:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1947 to July 21 1947 and that I last saw her alive on July 20 1947

Immediate cause of death Respiratory failure — Duration
Due to Arteriosclerotic heart disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 7/10/47

Major findings of operation: Ruptured pyelitic ulcer, ruptured hernia, arteriosclerosis

of autopsy: Heart disease

PHYSICIAN
*Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ....at ....M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry J Porter M. D.
Address 11 N. Joseph Hosp Date signed 7/21/47

G53627

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 B

Registered No. G53627

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Same

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Elkcott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Westchester Ave.
(If rural give location)
(e) Citizen of foreign country? [redacted] NO (Yes or No)
If yes, name country

3 (a) FULL NAME Howard D. Bloom

3 (b) If veteran, name war None

3 (c) Social Security Account No. 218-12-4855

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mrs. Bertha E. Bloom

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 22 March 1878

8. AGE: Years 69 | Months 4 | Days 28 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business Millwork

FATHER
12. Name John Thomas Bloom
13. Birthplace Unknown

MOTHER
14. Maiden Name Barbara ?
15. Birthplace Unknown

16 (a) Informant Mr. Howard T. Bloom
(b) Address Della Ave. Ellicott City, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/22/47. (month) (day) (year)
(c) Cemetery or crematory Poplar Springs Cemetery
Location Poplar Springs, Md.

18 (a) Funeral director Eastern Long
(b) Address Ellicott City, Md.

1947 JUL 21 Date received by Registrar Washington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 July 1947 at 4¼ M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/19 1947 to 7/20 1947 and that I last saw h.i.m. alive on 7/20 1947.

Immediate cause of death Shock - peripheral vascular

Due to HCVD

Due to Pulmonary infarct

Other Conditions Edema of brain
Fatty liver.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy (as above)

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph A. Natelson M.D.

Address West Baltimore General Hosp. Date signed July 21 1947

92)

~~G53628~~ To be approved MORGAN

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122 B

Registered No. G53628

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Reisterstown
(c) Hospital or institution: Univ. Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1715 ~~Highland Ave~~ 1718 Harlem Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Morgan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	M

6 (b) Name of husband ~~or wife~~

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years	Months	Days	If less than one day
46			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Not None
13. Birthplace " "

MOTHER
14. Maiden Name Not None
15. Birthplace " "

16 (a) Informant Thomas Morgan
(b) Address 1718 Harlem Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 21st 47 (month) (day) (year)
(c) Cemetery or crematory Mt Calo
Location Birdland Md

18 (a) Funeral director E Roy Wilson
(b) Address 1000 Pulaski Hy

19 (a) Filed July 21 1947 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-16-47 19 , at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-16 1947 to 7-16 1947 and that I last saw her alive on 7-16 1947

Immediate cause of death	Duration
Cardiac failure	
Due to ~~intestinal obstruction~~	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R. Rowell Jr. M. D.
Address Univ. Hosp. Date signed 7-16-47
for J. John R. Rowell, M. D. X
Howard J. Wilkins, M. D.

G53629
Dr Falconer

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. G53629

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 913 Shuter st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 913 Shuter st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amelia V. Chester

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 69 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name James H. Harvey
13. Birthplace md

MOTHER 14. Maiden Name Catherine P. Harvey
15. Birthplace md

16 (a) Informant Florence Miller
(b) Address 1120 E. Madison st

17 (a) Burial (b) Date thereof July 21, 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calv. Cem
Location Brooklyn, Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1700 Brantley ave

19 (a) [illegible] JUL 21 1947 Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/15 1947, to 7/17 1947, and that I last saw h[illegible] alive on 7/17 1947.

Immediate cause of death Cerebral Hemorrhage — Duration 2 days
Due to Hypertension
Due to
Other Conditions Myocarditis
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jesse A. Lefevre M.D.
Address 822 N. Bond St Date signed 7/21/47

82a

G53630 G53630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): less than 1 day
(e) Length of stay in Baltimore (yrs., mos., or days): less than 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: Cecil
(c) City or town: North East
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME: Alvin Albert Ford

3 (b) If veteran, name war: WW I
3 (c) Social Security Account No.: --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Anna Mae Cresswell Ford
6 (c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): Feb. 25, 1894

8. AGE:	Years	Months	Days	If less than one day
	53	4	26	....hr. ....min.

9. Birthplace: NorthEast, Md. (Town, county, and state)
10. Usual Occupation: None
11. Industry or business:

FATHER
12. Name: Edward Ford
13. Birthplace: NorthEast, Md.

MOTHER
14. Maiden Name: Nellie Shellcross
15. Birthplace: NorthEast, Md.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial, cremation, or removal: Burial Date thereof: July 24-47 (month) (day) (year)
(c) Cemetery or crematory: Methodist
Location: North East Md

18 (a) Funeral director: Joseph R. Stuart
(b) Address: North East Md

(Date rec'd by Registrar) July 21 1947 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH July 21 19 47, at 10:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 19 47 to July 21 19 47 and that I last saw him alive on July 21 19 47

Immediate cause of death: Coronary sclerosis with thrombosis; myocardial infarction — Duration: SEVERAL DAYS

Due to: ....

Due to: ....

Other Conditions: Diabetes mellitus — Duration: Unknown

(Include pregnancy within 3 months of death)

Date of operation: ....

Major findings of operation: ....

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: ....
(b) Date of occurrence: .... at .... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury: ....

23. Signature: C.F. Van Ackeren, M.D.
Address: Medical Officer in Charge Date signed: 7/21/47

94a

G53631

BALTIMORE CITY HEALTH DEPARTMENT ✓ G53631

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1532 Bolton St.
(c) Hospital or institution: ----------
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ----------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1532 Bolton St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ----------

3 (a) FULL NAME Melanie Boone Dugan

3 (b) If veteran, name war ----------
3 (c) Social Security Account No. ----------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband ~~if married~~ Ferdinand C. Dugan
6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) Dec. 26, 1875

8. AGE: Years	Months	Days	If less than one day
71	6	23	---hr. --- min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business ----------

FATHER
12. Name Daniel A. Boone
13. Birthplace Maryland

MOTHER
14. Maiden Name Melanie Carroll
15. Birthplace Little Rock, Arkansas

16 (a) Informant Cumberland Dugan
(b) Address 520 N. Charles St.

17 (a) Burial (b) Date thereof 7/22/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears & Son
(b) Address 805 N. Calvert St.

19 (a) Huntington Williams, M.D.
(Date received by registrar) Registrar

JUL 21 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1947, at 6:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/22 1947 to 7/19 1947 and that I last saw her alive on 7/19 1947.

Immediate cause of death	Duration
Coronary Thrombosis	4 wks.
Due to Coronary Arteriosclerosis	?
Due to	
Other Conditions Pulmonary Infarcts	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —
23. Signature Francis W. Gluck M.D.
Address 3406 St Paul St Date signed 7/21/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53632 — Edmon

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33A

G53632 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16 N Wolfe St
(c) Hospital or institution:
6-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 16 N. Wolfe St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edmon Neal Martin ✓

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Infant.

6 (b) Name of husband or wife March 27, 1947
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 27 1947

8. AGE: Years	Months	Days	If less than one day
	3	24	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Les. Martin
13. Birthplace Va.

MOTHER
14. Maiden Name Annabelle
15. Birthplace Willamont, Va.

16 (a) Informant Les. Martin
(b) Address 6 N. Wolfe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 21, 1947 (month) (day) (year)
(c) Cemetery or crematory Lohyatt Cem
Location Edmondson Ave.

18 (a) Funeral director Wendel & Kappel
(b) Address 3125 Hoffman St
21 1947 (Date received by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1947, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 1947, to July 20 1947, and that I last saw h. alive on July 19 1947.

Immediate cause of death	Duration
Influenza & Pneumonia	1 week
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Joseph Freedman M. D.
Address 506 E. Preston Date signed 7/21/47

VS 150

G53633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G53633 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 117 W. Perry
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 117 W Perry (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Williams

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years	Months	Days	If less than one day
49			hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Miner
11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Ethel V. Williams
(b) Address 117 W. Perry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 26-47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director James A Davis
(b) Address 142 W Stiles St
(c) JUL 22 1947 (Date received by registrar) Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1947 at 9a M

21. I certify that death occurred on the date above stated; that I attended deceased from May 18 1947 to July 21 1947.
and that I last saw him alive on July 5 1947

Immediate cause of death	Duration
Cardiac Hemorrhage	
Due to Tuberculosis	3 mo
Due to	
Other Conditions (over)	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature [illegible] M. D.
Address 1428 Eutaw Pl Date signed 7/24/47

G53634

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D ✓

G53634 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 509 W. Barre
(c) Hospital or institution: 22
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 509 W. Barre St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie Dickson

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Floyd Dickson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1904

8. AGE: Years 42 | Months 10 | Days | If less than one day hr. min.

9. Birthplace Ga.
(Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unk

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Irene Barber
(b) Address 210 Marbury St Crockett's Bay

17 (a) Burial (b) Date thereof (month) (day) (year) 7-22-47
(Burial, cremation, or removal)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director James A Taylor
(b) Address 1424 N Wolfe St

(a) JUL 22 1947 (b) Huntington Williams, MD
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-15 1947 to 7-18 1947 and that I last saw h[illegible] alive on 7-19 1947.

Immediate cause of death Cardio Vascular Disease — Duration 6 Mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Atwell Jones
Address 534 Dolphin St Date signed 7-19-47 M. D.

4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G53635

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-5
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 413 S. Smallwood St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) **FULL NAME** WILLIAM R. KENNEALLY, Sr.

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 213-05-2448

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary E. Kurtz
6 (c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) August 24, 1911

8. AGE: Years 35 | Months 10 | Days 26 | If less than one day .....hr. .....min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Warehouse Man
11. Industry or business: Meat Packing House

FATHER
12. Name: William E. Kenneally
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Mary A. Lang
15. Birthplace: Balto., Md.

16 (a) Informant: Mary E. Kenneally
(b) Address: 413 S. Smallwood Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 24 1947 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Balto Md

18 (a) Funeral director: Pratt Ct B.M. Walter
(b) Address: Pratt & Fricker Sts

19 (a) JUL 24 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20, 1947, at 7:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subarachnoid hemorrhage, traumatic

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-2-47 at approx. 6:15 P.M.
(b) Where did injury occur? (Tavern) Pratt & Monroe Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Blunt force

23. Signature Earl R. Gaye M.D. Medical Examiner.
Date signed.....

G53636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95C

G53636

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5909 Park Heights Ave.
(c) Hospital or institution:

27-20

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5909 Park Heights Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MINA SALOMON FLEISCHER.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Samuel E. Fleischer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 21, 1859

8. AGE: Years	Months	Days	If less than one day
88	4	-	hr. min.

9. Birthplace Germany.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Moses Salomon,
13. Birthplace Germany.

MOTHER
14. Maiden Name Karoline Hirsch,
15. Birthplace Germany.

16 (a) Informant Mr. Morton E. Fleischer,
(b) Address 5909 Park Heights Ave.

17 (a) Burial (b) Date thereof 7/23/47.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral director Harris Lomazow & Son
(b) Address 1902 Eutaw Place.

19 (a) JUL 22 1947 Huntington Williams, M.D.
(Registered by registrar) Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH July 21, 1947, at 1.35 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 16 1947 to July 21 1947, and that I last saw h.. alive on July 21 1947

	Duration
Immediate cause of death Pulmonary edema	8 hours
Due to Cardiac Hypertrophy	2 days.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.
Address Temple Garden Apts. Date signed

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186A

G53637 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hosp. 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 0a
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 15 E. York St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME August Rinkle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 9-24-1884

8. AGE: Years 62 | Months 9 | Days 26 | If less than one day ____ hr. ____ min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Chas. Rinkle
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Kraft
15. Birthplace Germany

16 (a) Informant Catherine Klein
(b) Address 524 S. Ellwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-23-47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Ritchie Highway

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. Wolfe St.

19 (a) JUL 22 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1947, at 5:35 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Fractured skull with intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 22/1

(a) Date of injury 7-20-47 at 4:45 P.M.
(b) Where did injury occur? 15 E. York St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury? fell from 2nd floor of home

23. Signature [signature] M.D. (Medical Examiner)

Date signed 7-21-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53638

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83A

Registered No. G53638

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2311 W. Lafayette Ave.
(c) Hospital or institution:
16-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2311 W. Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LAURA M. BARNES

3 (b) If veteran, name war: -
3 (c) Social Security Account No.: -

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Philip H. Barnes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1869

8. AGE: Years 77 | Months 10 | Days 18 | If less than one day hr. min.

9. Birthplace West Chester, Pa.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Stephen T. Smith
13. Birthplace Media, Pa.

MOTHER
14. Maiden Name Margaret Broadbent
15. Birthplace Limo, Pa.

16 (a) Informant Miss Marion Smith
(b) Address 39 S. High St., West Chester, Pa.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/23/47 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location West Chester, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date received by Registrar JUL 22 1947 (b) Thurlington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20, 1947 at 3:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1947, to July 20 1947, and that I last saw her alive on July 19 1947.

	Duration
Immediate cause of death: Cerebral Hemorrhage	4 days
Due to: Hypertension	7 years
Due to: Arteriosclerosis	"
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daniel J. Schwartz
Daniel J. Schwartz, M.D. M. D.
Address 2320 Eutaw Place Date signed 7-21-47

X

G53639

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48B

Registered No. G53639

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 722 Reservoir St.
(c) Hospital or institution: 13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 722 Reservoir St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELSIE THOMAS McGINLEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Edward McGinley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 24, 1882

8. AGE: Years	Months	Days	If less than one day
65	5	26	hr. min.

9. Birthplace Phila., Pa. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Edward Thomas
13. Birthplace Nashville, Tenn.

MOTHER
14. Maiden Name Alice E. Aker
15. Birthplace Withville, Va.

16 (a) Informant Mr. Edward McGinley
(b) Address 722 Reservoir St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/23/47 (month) (day) (year)
(c) Cemetery or crematory Arlington Cem.
Location Lansdowne, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUL 22 1947 (Date rec'd by registrar) (b) Huntington Williams Registrar

V S 190

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20, 19 47, at 8:05p. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 16 1947 to July 20 1947, and that I last saw Dec. alive on July 20 1947.

Immediate cause of death Carcinoma of uterus — Duration 8 mos. years

Due to — Duration years

Due to — Duration years

Other Conditions — Duration years

(Include pregnancy within 3 months of death)

Date of operation Jan 47.

Major findings of operation: Malignancy of uterus.

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward J. Cotter M. D.
Address 11 E. Chase St. Date signed July 24 '47

153640

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V83A

G53640 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 426 N. Mosher St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 426 N. Mosher St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lula Hatty Cummings

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Aaron

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4, 1865

8. AGE: Years 82 | Months 1 | Days 15 | If less than one day hr. min.

9. Birthplace Campbell C. Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. Harry S. Cummings
(b) Address 1318 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 22, 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Carl W. Hallowell
(b) Address 1631 Druid Hill Ave.

19 (a) JUL 22 1947 (Date rec'd by Registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1947, at 8 C M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 3 1946 to July 19 1947, and that I last saw h[illegible] alive on July 19 1947.

Immediate cause of death: Cerebral hemorrhage

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: Cerebral 1 1946

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. Garland Schmidt M. D.
Address 1534 Druid Hill Ave Date signed July 22

X

G53641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G53641

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3114 Barclay St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3114 Barclay St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Howard S. Cottings GIDDINGS

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary S.

6 (c) If alive, give age: 189 years

7. Birth date of deceased (mo., day, yr.) April 7, 1890

8. AGE: Years 57 | Months 3 | Days 17 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation U. S. Army

11. Industry or business

FATHER
12. Name James Cottings
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Mary S. Cottings
(b) Address 3114 Barclay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 22, 1947 (month) (day) (year)
(c) Cemetery or crematory Balto. Nat'l. Cem.
Location Baltimore, Md.

18 (a) Funeral director Wm. H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) ____ (Signature of registrar) (b) Huntington Williams, M.D.

JUL 22 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-18-47 19____, at 4:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-15-47 19____, to 7-18-47 19____, and that I last saw h[illegible] alive on 7-18-47 19____

Immediate cause of death: Coronary Occlusion — Duration: 5 Min

Due to: Occlusion

Due to:

Other Conditions: Pulm. congestion

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Morris Glaser, M. D.
Address 131 N. Carey St. Date signed 7-19-47

X

G53642

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

Registered No. G53642

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4702 HARFORD AVE. 15.
(c) Hospital or institution:
CONVALESENCE HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 MONTHS
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1919 CLIFTON AVE
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA ABELLE.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 4/10/1861
8. AGE: Years 86 | Months 3 | Days 10 | If less than one day ... hr. ... min.
9. Birthplace ST. MARYS Co. Md (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name George Abell
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Benson
15. Birthplace Md.

16 (a) Informant John W. Abell
(b) Address 1919 Clifton Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/23/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore
18 (a) Funeral director Martin Fahey & Sons
(b) Address 1827 W. North Ave.
19 JUL 22 1947 (Date rec'd by Registrar) (b) Huntington Williamsport Md

MEDICAL CERTIFICATION P

20. DATE OF DEATH JULY 20 1947 19..., at 7.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from JUNE 2 1947 to JULY 20 1947 and that I last saw her alive on JULY 20 1947.

Immediate cause of death	Duration
CHRONIC MYOCARDITIS, JUNE 2 1947	
Due to ARTERIOR SCLEROSIS	1947
Due to	
Other Conditions SENILITY.	

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation: NONE
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward Schaefer M.D.
Address 3013 ST PAUL STREET Date signed JULY 20 1947.

VS 150

X

G53643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G53643 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5737 Jonquil Ave
(c) Hospital or institution: 27-19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 51 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5737 Jonquil Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Lurie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Max
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business House Wife

FATHER
12. Name Joseph Barr
13. Birthplace Russia

MOTHER
14. Maiden Name Freda ?
15. Birthplace Russia

16 (a) Informant Mr Martin Lurie
(b) Address 5737 Jonquil Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July (month) (day) (year)
(c) Cemetery or crematory Hebrew Washington Road Cem
Location Washingtob Blvd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) July 22 1947 (Date) Huntington Williams, M.D. (registrar)

V S 150

MEDICAL CERTIFICATION

3.57

20. DATE OF DEATH July 21 1947, at A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 17 1947 to July 21 1947, and that I last saw her alive on July 21 1947

Immediate cause of death	Duration
Pulmonary Embolism	sudden
Due to Arteriosclerotic cardiovascular disease	20 +
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph Friedman M. D.
Address 1206 E. Fayette St. Date signed 7/24/47

X

G53644

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓93D

Registered No. G53644

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2032 E. Biddle St.
(c) Hospital or institution: 8-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2032 E. Biddle Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH RICHARD RABORG, SR.

3 (b) If veteran, name war
3 (c) Social Security Account No. 216-01-7753

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Catherine (nee Baker)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1882

8. AGE: Years	Months	Days	If less than one day
64	6	26	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Hatter
11. Industry or business M. S. Levy

FATHER
12. Name unknown
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Winifred Convoy
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Catherine Raborg - wife -
(b) Address 2032 E. Biddle Street

17 (a) Burial (b) Date thereof 7/23/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) 7-22-1947 (Huntington Williams M.D.)
(Date received by registrar) Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1947 at 12:00 M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1947 to July 20 1947 and that I last saw him alive on July 18 1947

Immediate cause of death	Duration
Arteriosclerotic Heart Disease	5 yrs.
Due to Acute Myocardial Failure	5 min.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Israel Kaser M.D. M. D.
Address 2413 E. Monument St. Date signed X 7/21/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53645

No. 82637 BALTIMORE CITY HEALTH DEPARTMENT Registered No. G53645

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Regusters

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife William (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 70 ? | Months | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wm Alexander Smithers
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-21-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances H. Hemsley
(b) Address 518 W. Biddle St.

19 (a) JUL 22 1947 (Date rec'd by Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19th/1947 19..., at 5.25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 19 43, to July 19 19 47 and that I last saw h 9r alive on July 19 1947

Immediate cause of death: Heart Failure — Duration: 6 mos

Due to: Hypertension & Arteriosclerotic Heart Disease — Duration: yrs

Due to:

Other Conditions: Acute Anemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Clarkenson Jr. M. D.
Address Balt. City Hosp. Date signed 7/24/47

92)

G53646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 93D

G53646
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Rd.
(c) Hospital or institution: 7-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 621 N. Potomac St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothea Freiberg

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 5, 1874

8. AGE: Years 73 | Months 6 | Days 16 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation --

11. Industry or business

FATHER
12. Name Carl Freiberg
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Hoffman
15. Birthplace Germany

16 (a) Informant Mrs. Katherine Robert
(b) Address 621 N. Potomac St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 24/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto. Md.

18 (a) Funeral director Philip Sturm & Sons
(b) Address 2024 Orleans St.

19 (a) Date July 22 1947 (b) registrar Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1947, at 10 30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to July 21 1947 and that I last saw her alive on July 20 1947

Immediate cause of death
Myocardial Rupture — July 18/47
Chronic Myocarditis — Jan 1 1947
Due to arteriosclerosis
Due to
Other Conditions Parkinsons Disease
Chronic arthritis.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Louis J. Krumen M. D.
Address 722 No. Kenwood Date signed 7/22/47

X

G53647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1568

G53647
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2522 KEYWORTH AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2522 KEYWORTH AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY AUSTRIAN

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace NEW PORT NEWS VA
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name JOHN AUSTRIAN
13. Birthplace AUSTRIA

MOTHER
14. Maiden Name ESTHER
15. Birthplace AUSTRIA

16 (a) Informant LILLIAN G. FUTTERMAN
(b) Address 2806 ULMAN AVE

17 (a) BURIAL (b) Date thereof 7-23-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory BALTO. HEBREW
Location BELAIR RD

18 (a) Funeral director JACK LEWIS INC
(b) Address 2100 EUTAW PLACE

19 (a) JUL 22 1941 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-21-47 19..., at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1920 to 7-21-1947, and that I last saw h...alive on 7-11-1947.

Immediate cause of death	Duration
Mesenteric thrombosis	3 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathan B. Herman M. D.
Address 1041 St. Paul St. Date signed 7-21-47

X

G53648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

G53648 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2307 CALLOW AVE
(c) Hospital or institution: 13-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2307 CALLOW AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HELEN WEIL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife JULIUS

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace GERMANY (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name JACOB
13. Birthplace GERMANY

MOTHER
14. Maiden Name HENRIETTA
15. Birthplace GERMANY

16 (a) Informant EDITH PALLMAN
(b) Address 2307 CALLOW AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7-22-47 (month) (day) (year)
(c) Cemetery or crematory ROSEDALE
Location PHILA. RD

18 (a) Funeral director JACK LEWIS INC
(b) Address 2100 EUTAW PLACE

JUL 22 1947 (Date received by registrar) Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-21-47 19.., at 7:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 to JULY 21 1947, and that I last saw h.. alive on July 20 1947.

Immediate cause of death	Duration
Coronary Occlusion	5 min.
Due to Generalized Arteriosclerosis	10 yrs.
Due to	
Other Conditions Diabetes	2 mos.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Herbert Tolle Stone
Address 1113 Linden Av. Date signed July 21, 1947 M.D.

94A

G53649

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947D

G53649 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 858 Vmi St.
(c) Hospital or institution: 18-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 858 Vmi St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	Widow

6 (b) Name of husband or wife Nancy Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1901

8. AGE: Years	Months	Days	If less than one day
45	10	8	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Marshall Thomas
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Susan Johnson
15. Birthplace Baltimore Md.

16 (a) Informant Helen Thomas
(b) Address 858 Vmi St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 22, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Lebanon
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St

19 (a) July 22 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 1947, at 3:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1947 to July 18 1947 and that I last saw him alive on July 17 1947

Immediate cause of death: Chronic Valvular Heart Disease — Duration: 1 yr.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Williams Frey M. D.
Address 198 Penna Ave Date signed 7/21/47

G53650 S. Sove -

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1949

Registered No. G53650

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 425 Winston Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 425 Winston (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Compton Bacon

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	married

6 (b) Name of husband or wife Ellice Kinsey
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Aug 2, 1886

8. AGE: Years	Months	Days	If less than one day
60	11	19	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation M. D.
11. Industry or business

FATHER
12. Name George C. Bacon
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Mary Ellen Compton
15. Birthplace Balto. Co. Md.

16 (a) Informant Mrs. W. C. Bacon
(b) Address 425 Winston Ave Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 24, 1947 (month) (day) (year)
(c) Cemetery or crematory Monkton Meth. Church
Location Monkton, Balto. Co., Md.

18 (a) Funeral director Landon M. Brooks
(b) Address Sparks, Md.

19 JUL 22 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1947 at 12:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3 Mar 1947 to 21 July 1947 and that I last saw him alive on 3 July 1947.

Immediate cause of death Myocardial Infarction 2nd attack — Duration 2 hrs.
Due to Coronary Sclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm L. Lee
Address 1214 N. Calvert St Date signed 24 July 47

X

G53651 BC# B-77587

BALTIMORE CITY HEALTH DEPARTMENT

McMILLION CERTIFICATE OF DEATH 1576

G53651
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 601 N. Broadway
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 19 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1417 E. Lafayette ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Warden McMillion Jr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, [illegible] of deceased

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-3-47

8. AGE: Years | Months 2 | Days 19 | If less than one day hr. min.

9. Birthplace Md. Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Walton McMillion
13. Birthplace W. Va.

MOTHER
14. Maiden Name Hazel Akins
15. Birthplace W. Va.

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 7/24/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Richwood Cemetery
Location Richwood, Nicholas Co. West Virginia

18 (a) Funeral director George J. Ruth Inc.

(b) Address 1735 Harford Ave. Balto: Md.

19 JUL 22 1947 (b) Huntington Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-21-1947, at 5:58 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-19-1947 to 7-21-1947 and that I last saw h[illegible]ive on 7-21-1947.

Immediate cause of death Atelectasis - RUL — Duration 1-2 weeks

Due to 1. Chronic Malnutrition
2. ? Aspiration

Due to

Other Conditions 1. Bilateral Cystic Dzpt 2. ? Congenital Ht Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Philip Brucer M. D.

Address Johns Hopkins Hosp Date signed 7-22-47

161a

G53652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. G53652

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [illegible]
(c) Hospital or institution: Mercy Hospital 15-10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 73 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4005 Belview Ave. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Agnes F. Reilly

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	widowed

6 (b) Name of husband or wife. Edward J. Reilly
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24, 1947

8. AGE: Years	Months	Days	If less than one day: hr.	min.
73	11	21	18	73

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

MOTHER | FATHER
12. Name Phillip E. Kelly
13. Birthplace Maryland.
14. Maiden Name Catherine Conner
15. Birthplace Maryland

16 (a) Informant Edward J. Reilly, Jr.
(b) Address 4005 Belview Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/25/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. H. Meare and Son
(b) Address 925 N. Calvert St.

19 JUL 22 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1947 at 1100 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947 to July 21 1947 and that I last saw h[illegible] alive on July 21 1947.

Immediate cause of death: carcinoma of uterus with metast. — Duration

Due to anes. —

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature N. B. Scott M. D.
Address Mercy Hospital Signed 7/21/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G53653

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 186a

Registered No. G53653

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3205 Elgin Ave.
(c) Hospital or institution: ---------- 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 92 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ----------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3205 Elgin Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ----------

3 (a) FULL NAME Sadie E. Wagner

3 (b) If veteran, name war ----------
3 (c) Social Security Account No. ----------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband ~~or wife~~ Max Wagner
6 (c) If alive, give age ---years

7. Birth date of deceased (mo., day, yr.) 1855

8. AGE: Years	Months	Days	If less than one day
92	---	---	---hr. ---min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Richard Johnson
13. Birthplace Ireland

MOTHER
14. Maiden Name Jemima Buskell
15. Birthplace Ireland

16 (a) Informant Miss Blanche Wagner
(b) Address 3205 Elgin Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/23/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location Baltimore, Md.

18 (a) Funeral director H. H. Mans and Son
(b) Address 805 N. Calvert St.

19 (a) JUL 22 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20, 1947, at 9.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 23 19 42 to July 20 1947. and that I last saw h~~e~~r alive on July 20 19 47.

Immediate cause of death	Duration
Fracture of left femur	2 days
Due to Arteriosclerotic Cardio-Vascular Disease.	
Due to Senility.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 15/7
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 7/19/47 at 1 P. M.
(c) Where did injury occur? 3205 Elgin Avenue (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fell out of bed to floor

23. Signature Albert Merrill M.D.
Address 302 Edmondson Ave Date signed 7/21/47

A. A. Merrill MD

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53654

BALTIMORE CITY HEALTH DEPARTMENT X
CERTIFICATE OF DEATH 1318

G53654
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Glyndon.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vance Blake Sturgill

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	single

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-13-42

8. AGE: Years	Months	Days	If less than one day
4	11	9	hr. min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Vance Sturgill
13. Birthplace N. C.

MOTHER
14. Maiden Name Virginia Brown
15. Birthplace N. C.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof: 7/23/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Piney Creek Cem.
Location Sparta, N. C.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (Date received by registrar) JUL 22 1947 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July - 22 1947, at 1.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July - 15 1947, to July - 22 1947, and that I last saw him alive on July - 22 1947.

Immediate cause of death	Duration
CARDIO-RESPIRATORY FAILURE	
Due to UREMIA	
Due to CHRONIC NEPHROSIS	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. A. Spencer M. D.
Address Johns Hopkins Hosp. Date signed 7/22/47

X

G53655 FIRMAN G53655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1950 B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully inquired for and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 8-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2009 Sinclair Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard W. Furman

3 (b) If veteran, name war WWI
3 (c) Social Security Account No. 212-14-2525

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1921

8. AGE: Years 26 Months 6 Days 13 If less than one day hr. min.

9. Birthplace Savage Md
(Town, county, and state)

10. Usual Occupation Labaratory
11. Industry or business Mt Royal Laundry

FATHER
12. Name Howard L. Furman Sr
13. Birthplace

MOTHER
14. Maiden Name Dora Myerson
15. Birthplace Md

16 (a) Informant Mrs Alice Mosley
(b) Address 2009 Sinclair Lane

17 (a) Funeral (Burial, cremation, or removal) (b) Date thereof 7/23/47 (month) (day) (year)
(c) Cemetery or crematory Pahmer
Location Baltimore Md

18 (a) Funeral director Wilhelm & Son
(b) Address 1214 E Pratt St

19. JUL 22 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1947, at 7:35 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic adhesive pericarditis
Acute pulmonary edema
Due to
Other Conditions Rheumatic heart, chronic

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard Weldon M.D.
Medical Examiner.
Date signed 7-21-47

VS 181

G53656

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G53656
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2913 Annunciade Road
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Shuler

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married (separated)

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 25, 1905

8. AGE: Years	Months	Days	If less than one day
41	9	22 27	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation waitress
11. Industry or business

MOTHER / FATHER
12. Name James C. Russell
13. Birthplace Virginia
14. Maiden Name Lottie Miller
15. Birthplace West Virginia

16 (a) Informant Libby Fuller
(b) Address Winchester Va

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 7/22/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Hebron
Location Winchester Va

18 (a) Funeral director Wilkerson & Son
(b) Address 127 E Cork St

JUL 22 1947 Winchester Virginia
(Date received by Local Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1947 at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 11 1947 to July 22 1947, and that I last saw h. alive on July 22 1947.

Immediate cause of death	Duration
Uremia	
Due to Hypertension	
Due to	over
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation July 16, 1947
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature W. B. Scott M. D.
Address Mercy Hospital Date signed 7/22/47

G53657

AB-111923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G53657

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Middle Rivers (If outside city or town limits, write RURAL and give town)
(d) Street No. Box-180-A Rt. 14 zone 20 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Merchant

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Susie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 2- 1886

8. AGE: Years	Months	Days	If less than one day
60	8	19	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Benyamin D Merchon
13. Birthplace ? Va

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Funeral (b) Date thereof 7/22/47 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Fulton
Location Fulton N Col Jno

18 (a) Funeral director Fulton Col Jno
(b) Address 1217 E Pont St

19 (a) Filed 7-22-1947 (Date received by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 19 47 at 8.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-6- 19 47 to 7-21 19 47, and that I last saw h im alive on 7-21 19 47.

Immediate cause of death Coronary occlusion — Duration 3 Weeks

Due to

Due to

Other Conditions Hypertension. Cardiovascular Disease

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard T. Binford M. D.

Address Balt. City Hosp. Date signed 7-21-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C53658

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C53658

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 532 St Mary Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 532 St. Mary St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Caroline Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1868

8. AGE: Years 78 | Months 10 | Days | If less than one day hr. min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Joseph T. Mitchell
(b) Address 532 St. Mary Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-22-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Adolphus Hailstead
(b) Address 918 Druid Hill Ave

19 (a) [illegible] Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18, 1947 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/17/47 to 7/18/47; and that I last saw h[illegible] alive on 7/18/47

Immediate cause of death	Duration
(a) Coronary Thrombosis	48 hours
Due to (b) Generalized Arteriosclerosis	
Due to (c) [illegible]	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Lee Thomas M. D.
Address [illegible] Date signed 7/19/47

C53659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓55E

Registered No. C53659

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1046 Brantlyane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1046 Brantlyane (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ernestine Curry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sampson Curry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 55 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housemaid

11. Industry & business

FATHER
12. Name John Thomas
13. Birthplace Md.

MOTHER
14. Maiden Name Celia Thomas
15. Birthplace Md.

16 (a) Informant Sampson Curry
(b) Address 1046 Brantlyane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/22/47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location

18 (a) Funeral director Elroy O Wilson
(b) Address 1046 Brantlyane

19 (a) JUL 22 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/18/ 1947, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/26/47 1947, to 7/18/ 1947 and that I last saw alive on 19

Immediate cause of death	Duration
Acute Myocarditis	2 days
Due to Tumor of abdomen	6 mo.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. T. Gunn M.D.
Address 522 N. Arlington Ave Date signed 7/21/47

G53660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G53660

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Sorrento Road
(c) Hospital or institution: Colonial Nursing Home 6-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. ~~2924~~ E Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Gail

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: John Gail
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 15 1871

8. AGE: Years 76 | Months | Days 5 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Henry Jersheid
13. Birthplace Md

MOTHER
14. Maiden Name Dont know
15. Birthplace Md

16 (a) Informant Mrs Burns
(b) Address 2631 Eastern Ave

17 (a) burial (Burial, cremation, or removal) (b) Date thereof July 23 1947 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave Balto Co

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St

19 JUL 22 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 19 5.30 am M

21. I certify that death occurred on the date above stated; that I attended deceased from July 17 1947 to July 20 1947 and that I last saw h.. alive on July 19 1947.

	Duration
Immediate cause of death: Chronic Myocarditis	
Due to: Arteriosclerotic Cardiovascular Disease	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Wolf M.D.
Address 1331 Eutaw Place Date signed 7-21-47 M.D.

X

G53661

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No. G53661

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3916 Gelston Drive
(c) Hospital or institution:

16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3916 Gelston Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ella Bonsall

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Charles E. Bonsall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 18, 1869

8. AGE: Years	Months	Days	If less than one day
77	10	2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business at home

FATHER
12. Name Valentine Heil
13. Birthplace Germany

MOTHER
14. Maiden Name Teresse Lauderback
15. Birthplace Germany

16 (a) Informant Miss Mamie Bonsall
(b) Address 3916 Gelston Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 23, 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director Charles J. Schwalb
(b) Address 3545 Frederick Ave.

19 JUL 22 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20, 1947, at 11.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from January 17 1944, to July 17, 1947, and that I last saw her alive on July 17, 1947

Immediate cause of death	Duration
Cardiac insuffiency	3 weeks
Due to Generalized arteriosclerais	4 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George A Kupp M. D.
Address 3030 Edmondson Ave. Date signed 7/22/47

VS 150

X

C53662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C53662

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Ave
(c) Hospital or institution:
Maryland Gen'l Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1510 Malster Ave #17
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Minnie L. Bowman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Richard L. Bowman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 24, 1869

8. AGE: Years 77 | Months 7 | Days 26 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Richard Fitzinger
13. Birthplace Md.

MOTHER
14. Maiden Name Liza Fanning
15. Birthplace Ireland

16 (a) Informant Mrs. Earl Bowman
(b) Address 530 E. 38th St.

17 (a) Burial (b) Date thereof 7/23/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto Md.

18 (a) Funeral director C. J. Fanning & Son
(b) Address 1438 E. Lafayette Ave.

19 (a) JUL 22 1947 Huntington Williams, Md.
(Accepted by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 July 1947, at 1:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 30 June 1947 to 20 July 1947 and that I last saw her alive on 20 July 1947.

Immediate cause of death
Coronary ~~Thrombosis~~ occlusion — Duration

Due to arteriosclerosis

Due to

Other Conditions varicose veins

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. T. McGowan M. D.
Address Maryland Gen. Hosp. Date signed 20 July 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

Heretofore made out in C. O.

G53663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 85

Registered No. G53663

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1910 Mosher St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1910 Mosher St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clinton Helderbrandt

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, ~~married, widowed~~, or ~~divorced~~

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 7, 1883

8. AGE: Years 63 | Months 11 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER — 12. Name Henry Helderbrandt
13. Birthplace Balt.

MOTHER — 14. Maiden Name Laura McMasters
15. Birthplace Balt.

16 (a) Informant Bertha A. Helderbrandt
(b) Address 1910 Mosher St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/24/47 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Md

18 (a) Funeral director Gilbert Cook Co.
(b) Address 1317 Ft Ave & Huntington Ave Williams, Md

19 JUL 22 1947 (Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1947, at 5 P M

21. I certify that death occurred on the date above stated that I attended deceased from Bed-rest see hosp 19 to 19, and that I last saw h alive on 19

Immediate cause of death Epilepsy,

Due to Repeated Care

Due to to Coronor

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation?

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A Evans M. D.
Address 612 N 40 St Date signed

Dr. Merrill no

G53664

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1210

Registered No. G53664

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2406 Crest Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2406 Crest Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Harry Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No. ~~214-22-9481~~

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Ellen Norman Brooks

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) May 3, 1883

8. AGE: Years 64 | Months 2 | Days 17 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Gardner

11. Industry or business Caretaker

FATHER
12. Name William Brooks
13. Birthplace N.Y.

MOTHER
14. Maiden Name Josephine Coons
15. Birthplace Md.

16 (a) Informant Ellen D. Brooks
(b) Address 2406 Crest Rd. 1947

17 (a) Burial (b) Date thereof 23rd July
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Ceme.
Location Pikesville Md.

18 (a) Funeral director Millard F. Lemmon
(b) Address 4611 Park Heights Ave.

19 Filed July 22 1947 Wharton Williams M.D.
(Date filed by City Registrar) Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1947, at 5:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 26 1947 to July 20 1947, and that I last saw him alive on July 20 1947

	Duration
Immediate cause of death: Congestive Heart failure	3 days
Due to: Chronic Interstitial Nephritis	5 yrs
Other Conditions: Mitral Stenosis Indefinite	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sherman R. Trants M.D.
Address 2601 Manhattan Ave Date signed 7/20/47

G53665 BC#B-81634 JL - 111419

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157a

Registered No. G53665

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospital 14+1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1418 Linden Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME BabyGirl Lunquest -Mickey

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1947

8. AGE: Years | Months: 1 | Days: 1 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Lunquest
13. Birthplace Va.

MOTHER
14. Maiden Name Mickey Koons
15. Birthplace Texas

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 7-17-47 (month) (day) (year)
(c) Cemetery or crematory B.C.H. Crematory
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) Filed JUL 22 1947 (b) Registrar Huntington Hollins, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 19 47 at 10:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 14 19 47 to July 15 19 47, and that I last saw h 8F alive on July 15 19 47.

Immediate cause of death	Duration
Cardiac Failure	2 days
Due to Hydrocephalus	1 month
Other Conditions Prematurity Anemia	1 month

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Hydrocephalus, Cortical Atrophy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Julian P. Griffin M. D.
Address Balt City Hosp. Date signed 17 July 1947

X

G53666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G53666
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto. City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Ellicott City (If outside city or town limits, write RURAL and give town)
(d) Street No. Doughregan Manor (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LUCINDA BEE BUTLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/20/47

8. AGE: Years	Months	Days	If less than one day
		1	10½ hr. s. min.

9. Birthplace Ellicott City, Howard Co., Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business ---------

FATHER
12. Name Preston Butler
13. Birthplace ?

MOTHER
14. Maiden Name Edna Reed
15. Birthplace ?

16 (a) Informant Mr. Preston Butler
(b) Address Ellicott City, Howard Co., Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

University Medical School JUL 24 1947

18 (a) Funeral director Commissioner of Health
(b) Address

JUL 22 1947 (Date received by Registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1, 1947, at 11 P M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Congenital Atelectasis

Due to Prematurity

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature M.D. (Medical Examiner)
Date signed

G52667

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164B

Registered No. G52667

Every item of information should be carefully supplied. The write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital b
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 248 N. Castle Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH F. ISZKIEWICZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of ~~husband~~ wife Catherine
6 (c) If alive, give age ~~Deceased~~ yrs

7. Birth date of deceased (mo., day, yr.) July 26-1884

8. AGE: Years	Months	Days	If less than one day
62 63	11	27	..... hr. ..... min.

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation Labor
11. Industry or business Alto City

FATHER
12. Name Jacob Iszkiewicz
13. Birthplace poland

MOTHER
14. Maiden Name Maryanna ?
15. Birthplace poland

16 (a) Informant Clara Iszkiewicz
(b) Address 248 So. Castle Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-25-47 (month) (day) (year)
(c) Cemetery or crematory ST. STANISLAUS
Location Baltimore Md.

18 (a) Funeral director George R Weber
(b) Address 705 S. Bond st

JUL 23 1947 (a) (Local registrar) (b) Huntington Williams M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21, 1947, at 2 p.m.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH (a) Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-21-47 12.25 P.M. Foot of ~~Montford Ave~~
(b) Where did injury occur? Baltimore, Md
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Jumped from wharf

23. Signature Earle K Brown, M.D.
Medical Examiner
Date signed 7-22-47

G53668 ✓ G53668

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. General Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20a
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 717 Poplar Grove (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Walter E Griffin

3 (b) If veteran, name war: War I

3 (c) Social Security Account No. 214-03-2768

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Florence Griffin

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) May 31, 1893

8. AGE: Years 54 | Months 1 | Days 20 21 | If less than one day: hr. min.

9. Birthplace So. Thomaston Maine (Town, county, and state)

10. Usual Occupation Assemblyn Man

11. Industry or business Martins

FATHER 12. Name Herbert H. Griffin

FATHER 13. Birthplace So. Thomaston Maine

MOTHER 14. Maiden Name Jenny McLiod

MOTHER 15. Birthplace Scotland

16 (a) Informant Mrs. Florence Griffin

(b) Address 717 Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/24/47 (month) (day) (year)

(c) Cemetery or crematory Balto. National Cem.

Location Baltimore, Md.

18 (a) Funeral director George W. Little

(b) Address 2700 Edmondson Ave.

19 (a) JUL 23 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1947, at 2:20 P M

21. I certify that I took charge of the remains described above, held an Inquest ~~Autopsy~~ thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH asphyxiation

Due to hanging

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-21-47 at 2:10 P M.
(b) Where did injury occur? N. W. Police Station
(c) Did injury occur at home, on farm, industrial place, in public place? Jail While at work? no
(d) Means of injury Hanged self with bath robe cord

23. Signature [illegible] M.D. Medical Examiner

Date signed 7-22-47

X

G53669 LW 111319

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G52869

CERTIFICATE OF DEATH 48B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Crownsville State Hosp.
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Flora Clayton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 48 ? | Months | Days | If less than one day hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Records Balto. City Hosp.
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 23-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Edward
Location W. A. Co. Md.

18 (a) Funeral director Dyson Thomas & Wright
(b) Address 721 Pusquitts St.

19 (a) July 23 1947 (Date received by local Registrar) (b) Huntington, Williams, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 1947, at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1947 to July 18 1947 and that I last saw her alive on July 18 1947

Immediate cause of death: Bronchopneumonia — Duration: 4 hours

Due to: Secondary Carcinoma — 6 weeks

Due to: Carcinoma of the ureters — unknown

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Examination

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. E. Thorne M. D.
Address 4940 Eastern Ave. Date signed 7-22-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G58670 | BALTIMORE CITY HEALTH DEPARTMENT | X V G58670

CERTIFICATE OF DEATH 83A

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 N Eutaw
(c) Hospital or institution: Elmhurst Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Sykesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. R.F.D
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Dorsey Day Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Rachel Isaacs
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 28 1874

8. AGE: Years	Months	Days	If less than one day
73	5	24	hr. min.

9. Birthplace Glenelg Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name George D. Day
13. Birthplace Md

MOTHER
14. Maiden Name Virginia Ridgley
15. Birthplace Md

16 (a) Informant Mrs Harry Cigler
(b) Address Sykesville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-25-47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Glenelg Md

18 (a) Funeral director J C Higinbothom
(b) Address Ellicott City Md

19 (a) (Date received by registrar) JUL 23 1947 Huntington Nolan, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1947, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 22 1947, to July 22 1947, and that I last saw h.i.m. alive on July 22 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Adv. atherosclerosis	
Due to	
Other Conditions Residual Paralysis right - from previous cerebral hem.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis Isaacs M.D.
Address 1708 Eutaw Place (17) Date signed July 22 '47

X

G53671

BALTIMORE CITY HEALTH DEPARTMENT ✓ G53671 Registered No.

CERTIFICATE OF DEATH 937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1824 Presstman St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1824 Presstman St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN H. GIBSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Anna J. Gibson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22, 1896

8. AGE: Years	Months	Days	If less than one day
51	2	28	hr. min.

9. Birthplace Bryansville, Penna.
(Town, county, and state)
10. Usual Occupation Waiter
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace " "

MOTHER
14. Maiden Name Racheal Gibson
15. Birthplace Penna.

16 (a) Informant Mrs. Anna J. Gibson
(b) Address 1824 Presstman St.

17 (a) Burial (b) Date thereof 7-24-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. National Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (Dated rec'd by registrar) (b) Registrar

JUL 28 1947

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20, 1947 at 4:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1946 to July 20 1947
and that I last saw him alive on July 20 1947.

Immediate cause of death	Duration
Hypertension Cardio Vascular Disease	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.
Address 120 71 Conth St Date signed July 22, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53672 — BALTIMORE CITY HEALTH DEPARTMENT ✓ — G53672

CERTIFICATE OF DEATH

§3a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mt. Balt. Genl Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1515 Lanvale St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EDWARD D. GRAHAM

3 (b) If veteran, name war: W
3 (c) Social Security Account No.:

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charlotte L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 11 1883

8. AGE: Years 61 | Months 7 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Master Plumber

11. Industry or business Self

FATHER — 12. Name Sommers Graham
13. Birthplace Ireland

MOTHER — 14. Maiden Name Mary Hilton
15. Birthplace Baltimore Md

16 (a) Informant Glenn E. Graham
(b) Address 2710 Aisquith

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/25/47 (month) (day) (year)
(c) Cemetery or crematory Westview Location Baltimore Md

18 (a) Funeral director Wilson Conway Jr.
(b) Address 1217 E. Monument

19 (a) Filed by registrar (b) Registrar

JUL 25 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/21 1947 at 9:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/21 1947 to 7/21 1947 and that I last saw him alive on 7/21 1947.

Immediate cause of death CEREBRO VASCULAR ACCIDENT — Duration

Due to HYPERTENSION & ARTERIOSCLEROSIS

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Gutenberg M. D.

Address 200 W. North Ave Date signed 7/21/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53673 ✓ G53673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1018 Warden Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Grant GRANT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 19 1865

8. AGE: Years 81 | Months 7 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name William Peregory

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Mary Lutekust

15. Birthplace Baltimore Md.

16 (a) Informant Mary Moss

(b) Address Miami Fla.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 25 1947 (month) (day) (year)

(c) Cemetery or crematory Lutherville Md.

Location Baltimore Md.

18 (a) Funeral director Wilson & Son

(b) Address 1217 E. Fort Ave.

19 (a) (Date rec'd by Registrar) (b) Huntington Williamsport Md. (Registrar)

JUL 28 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1947, at 10 07 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 7 1947 to July 21 1947, and that I last saw h.e.d. alive on July 21 1947.

Immediate cause of death: Cerebral vascular accident — Duration: 36 hrs.

Due to: Arteriosclerosis — yrs.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. Otis Montgomery M.D.

Address Mercy Hospital Date signed July 22 1947

X

G53674

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G53674
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 106 E 25th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Algernon P. Coman

3 (b) If veteran, name war: W
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Lavinda C
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1897

8. AGE: Years 50 | Months 2 | Days 7 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Refrigeration Operator
11. Industry or business R R Co

FATHER
12. Name Lavin Coman
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Lavinda P Coman
(b) Address 106 E 25th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/25/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Tallon & Sons
(b) Address 1214 Park Ave

19 (a) (Date filed by registrar) 7-25-47 (b) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1947 at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an Susp Ed Inq thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio-Vascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J Helfrich M.D.
Medical Examiner.
Date signed July 22, 1947

G53675

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94A

G53675
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Cathedral & Madison
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State District of Columbia
(c) City or town Washington
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7331 14th St., Northwest
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Edwards Burns

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Dorothy B. Burns
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27-1898

8. AGE: Years	Months	Days	If less than one day
48	8	25	hr. min.

D.S.N.
9. Birthplace Washington D.C.
(Town, county, and state)
10. Usual Occupation Self Employed
11. Industry or business

FATHER
12. Name James A. Burns
13. Birthplace Rockville Md.

MOTHER
14. Maiden Name Margaret C. Foster
15. Birthplace Washington D.C.

16 (a) Informant Mrs Dorothy B. Burns
(b) Address 7331 - 14th St. Wash. DC

17 (a) Burial (b) Date thereof 7-23-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Washington D.C.

18 (a) Funeral director Plumpe Flemying
(b) Address 1426 Light St

19 (a) JUL 23 1947 (b) Registered
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/22/47 19..., at 10:00 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 7/22/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53676

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46

G53676 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3507 Powhatan Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Powhattan
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3507 Powhatan Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALFRED C. RICE, Sr.

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Mabel E. Rice
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1871

8. AGE: Years	Months	Days	If less than one day
75	6	24 25	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John T. Rice
13. Birthplace England

MOTHER
14. Maiden Name Elizabeth Needham
15. Birthplace England

16 (a) Informant Mr. Alfred C. Rice, Jr.
(b) Address 208 Paddington Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/23/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUL 23 1947 (Date rec'd by registrar) Registrar
Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21, 1947, at 8 22 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 17 1947 to July 21 1947.
and that I last saw him alive on July 21 1947.

Immediate cause of death	Duration
Lobar Pneumonia	5 days
Due to	
Due to	
Other Conditions Carcinoma of Oesophagus (Include pregnancy within 3 months of death)	6 months

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature William J. Sullivan M. D.
Address 2911 Garrison Blvd Date signed 7-21-47

G53677

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

G53677 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 410 Rosebank Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 410 Rosebank Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Henry Holmes

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widower

6 (b) Name of husband or wife Catherine T. Holmes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28, 1858

8. AGE: Years	Months	Days	If less than one day
89	0	23	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Silversmith

FATHER
12. Name Thomas Holmes
13. Birthplace England

MOTHER
14. Maiden Name Margaret Steinacker
15. Birthplace Germany

16 (a) Informant Mrs. Robert McDowell
(b) Address 410 Rosebank Ave.

17 (a) Burial (b) Date thereof 7/24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director [illegible]
(b) Address [illegible]

19 (a) JUL 23 1947 [illegible]
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 July 1947, at 9:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1947 to 21 July 1947 and that I last saw him alive on 20 July 1947

Immediate cause of death	Duration
Arteriosclerotic Cardio-Vascular Disease	6 yr.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. H. Ramme, Jr. M.D.
Address 501 Sheridan Ave. Date signed 24 July 47

G53678

BALTIMORE CITY HEALTH DEPARTMENT ✓ G53678
CERTIFICATE OF DEATH 49A Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Jewish Hosp of Baltimore
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3907 N. Rogers Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Renninger, Florence May

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife: William Renninger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1883

8. AGE: Years 63 | Months 7 | Days 15 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas E. Coard
13. Birthplace Virginia

MOTHER
14. Maiden Name Lelia Kelleam
15. Birthplace Virginia

16 (a) Informant Mr. Herbert T. Coard, brother
(b) Address 3907 N. Rogers Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/24/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUL 23 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1947, at 8 P M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 17 1947 to July 21 1947 and that I last saw her alive on July 21 1947

Immediate cause of death: Pulmonary Embolism — Duration

Due to

Due to

Other Conditions Generalized Carcinomatosis
(Include pregnancy within 3 months of death)

Date of operation July 21, 1947

Major findings of operation: Carcinoma of Ovary

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ernest Scher M. D.
Address Date signed

VS 150

NIA

G53379

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 138

G53679
Registered No.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2010 E. Pratt St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2601 Fait ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter A. Nowak

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-5841

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Stella
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 13 1906

8. AGE: Years	Months	Days	If less than one day
40	7	8	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business National Can Co.

FATHER
12. Name August Nowak
13. Birthplace Poland

MOTHER
14. Maiden Name Ludwika Pasela
15. Birthplace Poland

16 (a) Informant Mrs Stella Nowak
(b) Address 2601 Fait Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-24-47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

JUL 23 1947 (Date received by local registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION 955

20. DATE OF DEATH July 21 1947, at 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 12 1947, to July 21, 1947, and that I last saw him alive on July 19, 1947

Immediate cause of death	Duration
Pulmonary Tuberculosis	7
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Ehrlich
Address 730 W. Balto. St Date signed 7/21/47

X

G53680

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

✓ G53680 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 5th
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Jefferson St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13, 1924

8. AGE: Years	Months	Days	If less than one day
23	6	6	hr. min.

9. Birthplace Anderson, South Carolina
(Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business

FATHER
12. Name Ernest Jones, Sr.
13. Birthplace Anderson, S. C.

MOTHER
14. Maiden Name Janie Simpson
15. Birthplace South Carolina

16 (a) Informant Lillie Mae Jones
(b) Address 1200 Jefferson St.

17 (a) Burial (b) Date thereof 7/23/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory U.S. Colored
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) 7-22-1947 (b) Huntington Williams, M.D.
(Date received by local registrar)

VS 191

MEDICAL CERTIFICATION 35

20. DATE OF DEATH 7-18-1947 at 11 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemorrhage due to stab wound of heart

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-18-47 at 10:30 P.M.
(b) Where did injury occur? In front of 1108 Lexington St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Stabbing - Sharp Instrument

23. Signature Earl L. Virts M.D.
Medical Examiner.
Date signed 7-19-47

G53681

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

CEK-110428 46 B

Registered No. G53681

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 806 Druid Hill Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
70 ?			hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 7-31-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 (a) JUL 23 1947 (b) Huntington Williams, M.D.
(Date received) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 1947, at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1947, to July 18 1947 and that I last saw her alive on July 18 1947

Immediate cause of death	Duration
Carcinoma of Stomach	6 mos?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Robinson Jr. M. D.
Address Balt City Hosp Date signed 7/19/47

G53682 G53682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 105 N. Fremont Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 105 N. Fremont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth Paul

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: C
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mrs Hennie Paul
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 5, 1917

8. AGE: Years 30 | Months 5 | Days 16 | If less than one day hr. min.

9. Birthplace Greenville, N. C.
(Town, county, and state)

10. Usual Occupation Employment Office

11. Industry or business

FATHER
12. Name Babson King
13. Birthplace Wilson, N.C.

MOTHER
14. Maiden Name Addie Best
15. Birthplace La Grange, N.C.

16 (a) Informant Mrs Hennie Paul
(b) Address 105 N. Fremont Ave,

17 (a) Burial (b) Date thereof 7-25 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Star.
Location Catonsville Md.

18 (a) Funeral director Mrs Kate R. Ellis
(b) Address 322 N. Schroeder St

19 (a) (b)
(Signature of registrar)

JUL 23 1947

S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1947 at 12:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1947 to July 21 1947 and that I last saw h[illegible] alive on July 21 1947

Immediate cause of death	Duration
Pulmonary Edema	
Due to Chr. Endocarditis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. F. Howell M. D.
Address 601 N. Carrollton Ave Date signed 7/29/47

G53683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G53683 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dead
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1401 Bond Court
(If no street address give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William West

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Annie West

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1882

8. AGE: Years: 65 | Months | Days | If less than one day: hr. min.

9. Birthplace: Anne Arundel Co Md.
(Town, county, and state)

10. Usual Occupation: Labourer

11. Industry or business

FATHER
12. Name: Frank West.
13. Birthplace: Anne Arundel Co. Md

MOTHER
14. Maiden Name: Ida Mason.
15. Birthplace: Anne Arundel Co. Md

16 (a) Informant: Mrs. Annie West.
(b) Address: 1401 Bond Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-24-1937 (month) (day) (year)
(c) Cemetery or crematory: Mt. Zion
Location:

18 (a) Funeral director: Mrs. Kate [redacted] Williams
(b) Address: 332 N. Schroeder St.

19 (a) JUL 23 1937 (Date rec'd by registrar) (b) [redacted] Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/24 1937 at 5:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [redacted] M.D.
Medical Examiner.
Date signed 7/24/37

G53684

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V108

G53684 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 515 Sea Gull Ave.
(c) Hospital or institution: Home.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Nil.
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ——
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 515 Seagull ave.
(If rural give location)
(e) Citizen of foreign country? ——— (Yes or No)
If yes, name country ———

3 (a) FULL NAME Freddie Lomba Russell

3 (b) If veteran, name war ——— 3 (c) Social Security Account No. ———

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Negro	Widowed

6 (b) Name of husband or wife Alfred Lomba. Dead 6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) July 31, 1897

8. AGE: Years	Months	Days	If less than one day
49 yrs.	11	22	— hr. — min.

9. Birthplace Madison, Md. (Town, county, and state)
10. Usual Occupation ———
11. Industry or business ———

FATHER
12. Name Frank Kane
13. Birthplace Madison, Md.

MOTHER
14. Maiden Name Rosie Ethar
15. Birthplace Madison Md.

16 (a) Informant Son, Mr Sinclair Lockhart
(b) Address 515 Seagull ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-26-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location ———

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) ——— (Date received by registrar) (b) Keating for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-22 1947, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-14 1947 to 7-21 1947, and that I last saw her alive on 7-21 1947.

Immediate cause of death Lobar Pneumonia — Duration

Due to ———

Due to ———

Other Conditions Pleurisy & effusion

(Include pregnancy within 3 months of death)

Date of operation ———

Major findings of operation: ———

of autopsy: ———

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ———
(b) Date of occurrence ——— at ——— M
(c) Where did injury occur? ——— (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ——— While at work? ———
(Specify type of place)
(e) Means of injury ———
23. Signature Jerry L. Tuck M. D.
Address 363 Belvedere Date signed 7/23/47

VS 150

G53685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G53685
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 819 S. Stricker St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul Hammond

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-12-7136

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 62 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Silas Miller

13. Birthplace S. C.

MOTHER 14. Maiden Name Winnie Hammond

15. Birthplace S. C.

16 (a) Informant Annie Hammond

(b) Address 674 W. Fairmount Ave.

17 (a) Disposition (Burial, cremation, or removal) (b) Date thereof 7-25-47 (month) (day) (year)

(c) Cemetery or crematory Lynchburg S. Carolina

Location Box S. Carolina

18 (a) Funeral director Walter B. Long & Son

(b) Address 139 W. Hamburg St.

(c) Date received by registrar JUL 23 1947 Watkins Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1947, at 10:15 M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature William A. Kelsch M.D. Medical Examiner

Date signed July 22, 1947

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G53686

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dna
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 246 S. Eighteen St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John De Fazio

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18-1886

8. AGE: Years	Months	Days	If less than one day
61	3 2	4 14	hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Bethl Steel Co

FATHER 12. Name Michel De Fazio

13. Birthplace Italy

MOTHER 14. Maiden Name Mary Trotta

15. Birthplace Italy

16 (a) Informant Mary Fitzpatrick

(b) Address 608 S. Bouldin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 25-47 (month) (day) (year)

(c) Cemetery or crematory H. Shanahan

Location O'Donnell Rd

18 (a) Funeral director John A. Mahon

(b) Address 3000 E. Balto. St.

19 (a) JUL 29 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1947, at 12:15 P.M.

21. I certify that I took charge of the remains described above, held an Insp & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary artery disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Earl L. Fazer M.D. Medical Examiner.

Date signed 7-22-47

X

G53687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

G53687 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name county)
(d) Street No. 3613 Copley Pl. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Young.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed.

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec 2-1883

8. AGE: Years	Months	Days	If less than one day
63	7	19	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Retired.
11. Industry or business

FATHER
12. Name Geo. Young
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Emma Vineyard
15. Birthplace Balto. Md.

16 (a) Informant Balto. Relt.
(b) Address 3613 Copley Pl.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 25/47 (month, day, year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director John A. Wilson
(b) Address 4261 Greenmount Ave

19 (a) 1947 (b) (Date filed by registrar) Registrar

23 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1947, at 5:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/11 1947 to 7/21 1947, and that I last saw him alive on 7/21 1947

Immediate cause of death Coronary Occlusion — Duration 2 wks.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation Peritoneal Cauterization
Major findings of operation: Benign Prostatic Hypertrophy
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank C. Cleaver M.D.
Address Md. Gen'l Hosp. Date signed 7/21/47

X

G53688

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G53688 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 18 N. Linwood a.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) b
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town, but in State, write RURAL and give town)
(d) Street No. 18 N. Linwood a (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine T King

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Jack E. W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23 - 1908

8. AGE: Years 39 | Months 5 | Days 26 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name John Trawinski
13. Birthplace Poland.

MOTHER
14. Maiden Name Kath. Marcalite
15. Birthplace Poland.

16 (a) Informant Julia Trawinski
(b) Address 18 N. Linwood av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 24/47 (month) (day) (year)
(c) Cemetery or crematory Holy Cr.
Location Belair Rd.

18 (a) Funeral director John. D. Mahon
(b) Address 306 E. Balto. St.

19 (a) 1947 (b) [illegible] Registrar
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21- 1947, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1947, Died of cardiac and that I last saw h alive on 19

Immediate cause of death	Duration
Coronary Thrombosis	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. J. Kelly MD
Address 100 N. Linwood Ave Date signed July 24 1947

H. J. Merrill MD

G53689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G53689 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3014 Gibbons Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3014 Gibbons Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine M. Kellermann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-26-1887

8. AGE: Years	Months	Days	If less than one day
60	6	28	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name Anthony M
13. Birthplace Md.

MOTHER 14. Maiden Name Catherine A Roth
15. Birthplace Wash.

16 (a) Informant Mrs Jos. Kistlein
(b) Address 3014 Gibbons Ave

17 (a) Burial (b) Date thereof 7-26-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director Leonard J Roth
(b) Address 520 Harford Rd

19 (a) (Date received by registrar) (b) Registrar Huntington Williams, M.D.

JUL 29 1947

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-23 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1947 to July 23 1947
and that I last saw h[illegible] alive on July 15 1947

Immediate cause of death	Duration
Metastatic Carcinoma of Lung.	
Due to Primary Cancer of Breast.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation June 9, 1947
Major findings of operation: Cancer of Breast.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas J. Brennan M. D.
Address 5217 Harford Rd Date signed 7-23-47

Dr. James Insley
437 [illegible] Dr.
G53690

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G53690
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 East Chase Street
(c) Hospital or institution:
8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2803 East Chase Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew A. Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Emma M. Miller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29, 1887

8. AGE: Years 60 | Months 1 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Emma M. Miller
(b) Address 2803 East Chase Street

17 (a) Burial (b) Date thereof 7/25/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

(a) (b)
(Filed by registrar) Registrar

JUL 23 1947

V S 150 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21st, 1947, at 10:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 1947 to July 21 1947, and that I last saw him alive on July 21 1947

Immediate cause of death — Duration
Left heart failure — 1 day
Due to
Coronary thrombosis — 1 week
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James K. Insley Jr M. D.
Address 936 E. Baltimore St Date signed 7/23/47

24 X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G53691 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4022 Bellewood Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4022 Bellewood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lena (Jeans) Beckwald Beckwold

3 (b) If veteran, name war

3 (c) Social Security Account No. 12-4-1893

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Ingeborg O.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 4, 1893

8. AGE: Years	Months	Days	If less than one day
53	7	18	hr. min.

9. Birthplace Norway
(Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business Shoe mfg.

FATHER
12. Name Peter
13. Birthplace Norway

MOTHER
14. Maiden Name Marie
15. Birthplace Norway

16 (a) Informant Ingeborg O. (Beckwald) Beckwold
(b) Address 4022 Bellwood

17 (a) Burial (b) Date thereof July 25, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore Md.

18 (a) Funeral director Leonard J. Rank
(b) Address 5305 Harford Rd Baltimore

19 (a) JUL 23 1947 (b) Arlington Williams Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/22 1947 at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] Medical Examiner. M.D.
Date signed 7/23/47

Aleeko

G53692

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 53

G53692
Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The PLEASE WRITE PLAINLY, WITH UNFADING INK. Exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution:
Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Rural - Towson.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Shepherd & Enoch Pratt Hosp.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES K. ABRAHAMS

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	216-12-3833 A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	single

6 (b) Name of husband or wife –
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 3, 1863

8. AGE: Years	Months	Days	If less than one day
83	8	19	hr. min.

9. Birthplace Port Deposit Maryland
(Town, county, and state)
10. Usual Occupation Insurance agent retired
11. Industry or business Green & Abrahams

FATHER
12. Name Cornelius Abrahams.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Clara D Vannerman.
15. Birthplace Maryland

16 (a) Informant Shepherd Pratt Hosp
(b) Address Towson, Md.

17 (a) Burial (b) Date thereof 7/24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hopewell Cem.
Location Cecil Co., Md.
18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Filed by registrar (b) Registrar

JUL 23 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1947 at 2A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 1947 to July 22 1947 and that I last saw him alive on July 22 1947

Immediate cause of death	Duration
Bronchopneumonia	4 days
Other Due to Diabetic gangrene	?
Diabetes Mellitus	?
Due to Carcinoma of Scalp	?
Other Conditions Arteriosclerosis.	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature John M. Gelbach M. D.
Address Shepherd Pratt Hosp Baltimore Md. Date signed

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G53693
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5215 Midwood Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5215 Midwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Francis G. Rosenstiel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Estelle Bourke
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11, 1866

8. AGE: Years	Months	Days	If less than one day
81	-	11	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Bank

FATHER
12. Name Leo Rosenstiel
13. Birthplace

MOTHER
14. Maiden Name Frances R. Rosenstiel
15. Birthplace

16 (a) Informant Mrs. E. Dempsey
(b) Address 5215 Midwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 25 1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 East Biddle St.

(a) Date received by registrar JUL 23 1947 (b) Registrar Curtis Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22, 1947 at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 1944 to July 22 1947, and that I last saw h/3 alive on July 22 1947.

Immediate cause of death Generalized Arteriosclerosis - Hypertensive Cardio-Vascular disease — Duration 4 yrs.
Due to — 4 yrs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas F. Dempsey M. D.
Address 5217 York Rd Date signed 7/23/47

X

G53691

G53691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4309 Stanwood Ave
(c) Hospital or institution:
Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Balto - (b) County Balto
(c) City or town Balto -
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4307 Stanwood Ave
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Virginia Santmyer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Oscar Santmyer
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 3-16-02

8. AGE: Years	Months	Days	If less than one day
45	4	6	..... hr. ..... min.

9. Birthplace West Virginia
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Sam Rutherford
13. Birthplace West Virginia

MOTHER
14. Maiden Name Maude Boswell
15. Birthplace West Virginia

16 (a) Informant Oscar Santmyer
(b) Address 4309 Stanwood Ave

17 (a) Burial (b) Date thereof July 26
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2 E Chase St
(c) .....
(Date rec'd by registrar) JUL 23 1947 (Registrar) Huntington Willis Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 July 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 22 July 1947 to 22 July 1947 and that I last saw h.s.t. alive on July 22 1947.

Immediate cause of death	Duration
Hemorrhage	
Due to Cancer of the Cervix	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: .....
of autopsy: Cancer Cervix

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Maynard R Bowers M.D.
Address F. St. Hospital Date signed 7-22-47

G53695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G53695 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Rocks
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Earl Heaps Schilling

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Florence E. Young

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 8, 1895

8. AGE: Years	Months	Days	If less than one day
51	7	15	hr. min.

9. Birthplace Harford Co., Md (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Howard L. Schilling
13. Birthplace Harford Co. Md

MOTHER
14. Maiden Name Mary Rebecca Heaps
15. Birthplace Farmgrove Pearl.

16 (a) Informant Mrs. Ruth Young Schilling
(b) Address Rocks, Md.

17 (a) Burial (b) Date thereof 7-27-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Jarrettsville
Location Jarrettsville Md.

18 (a) Funeral director Martin G. Kurtz
(b) Address Jarrettsville Md

19 (a) (Date filed by registrar) (b) Huntington Wilson, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1947, at 7:30 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Acute edema of lungs.
Fracture of pelvis.
Dilatation of heart.
Fat infiltration of liver.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7/19/47 at 7:30 P. M.
(b) Where did injury occur? Federal Hill Road 300' west R.R. grade crossing
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury. Pedestrian in auto vehicle accident

23. Signature Thos. G. Merrill M.D.
Medical Examiner.
Date signed 7-23-47

G53696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 169

G53696

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen. Hosp'l
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24a
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 28 S. Regester St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Francis COOPER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1923

8. AGE: Years	Months	Days	If less than one day
24			hr. min.

9. Birthplace Servisetta Va (City, county, and state)

10. Usual Occupation Car Rider

11. Industry or business B. & O. Coal Pier

FATHER
12. Name John Cooper
13. Birthplace Servisetta Va

MOTHER
14. Maiden Name Emma Cooper
15. Birthplace Servisetta Va

16 (a) Informant Thelma Cooper
(b) Address 6 N. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 24 47 (month) (day) (year)
(c) Cemetery or crematory Servisetta Cem
Location Servisetta, Va.

18 (a) Funeral director Elroy D. Wilson
(b) Address 1000 Baltimore Ave

19 (a) (Date received) JUL 23 1947 (Huntington Williams, M.D. Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1947, at 11:20 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Traumatic amputation, left arm
Crushing of both legs
Due to Multiple fractures

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 25/5
(a) Date of injury 7-19-47 at 10:30 P M.
(b) Where did injury occur? Yd. of Benhill St. - Curtis Bay B. & O. R.R. Coal Yards
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial Place While at work? yes
(d) Means of injury Crushed between 2 coal cars

23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 7/21/47

X

G53697

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1258

G53697 Registered No. 4747

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 232 So Dunbar St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 40

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 232 So Dunbar St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lora Smith

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
61			hr. min.

9. Birthplace Cambridge Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Saul Banks
13. Birthplace Cambridge Md

MOTHER
14. Maiden Name Mary Scott
15. Birthplace Cambridge Md

16 (a) Informant Fannie M. Pyson
(b) Address 618 Bethel St

17 (a) Burial (b) Date thereof July 23-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Baltimore Md

18 (a) Funeral director Elroy B. Wilson
(b) Address 1 [illegible] Baltimore Md

19 (a) Filed JUL 23 1947 (b) Signature of registrar [illegible] Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 1947, at 1 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-26 1945 to 7-12-47 1947 and that I last saw her alive on 7-12 1947.

Immediate cause of death	Duration
Acute Hepatitis	2 wks
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature R B Lightsey M. D.
Address 501 Cherry Hill Rd Date signed 7-21-47

X

G53698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G53698 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution: Church Home & Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Hour
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Minute

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 HOMESTEAD ST (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME BABY Girl Allen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/15/47

8. AGE: Years | Months | Days | If less than one day 0 hr. 1 min.

9. Birthplace BALTIMORE, Maryland (Town, county, and state)

10. Usual Occupation BABY

11. Industry or business

FATHER
12. Name John Daniel Allen
13. Birthplace BALTIMORE

MOTHER
14. Maiden Name MARGARET HOUSER
15. Birthplace BALTIMORE

16 (a) Informant MARGARET ALLEN
(b) Address 1618 HOMESTEAD ST

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JUL 21 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 JUL 23 1947 Registered by [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/15 1947, at 10:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/15 1947 to 7/15 1947 and that I last saw her alive on 7/15 1947

Immediate cause of death	Duration
Respiratory FAILURE	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. J. Kohlenberg M.D.
Address Church Home & Hosp. Date signed July 21 47

G53699

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1467

G53699
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days) 20 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 946 N. Durham St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Purnell Fitzgerald

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife: Moses Fitzgerald
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) 2-6-1902

8. AGE: Years 45 | Months 5 | Days 16 | If less than one day ... hr. ... min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Luther Boone
13. Birthplace Va.

MOTHER 14. Maiden Name Rosa Hardawick
15. Birthplace Va.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof July 5 47 (month) (day) (year)
(c) Cemetery or crematory
Location Crewe Va.

18 (a) Funeral director Mc Lott & Elliott
(b) Address 1129 N. Caroline St.

19 (a) JUL 7 1947 (Date received by registrar) (b) Huntington Williams M.D.

VS -150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-22 1947, at 8.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-22 1947 to 7-22 1947.
and that I last saw her alive on 7-22 1947.

Immediate cause of death	Duration
Hemorrhage of Rectum	
Due to Cerebral Embolism.	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert L. Brown M. D.
Address 1500 Hopkins Pl. Date signed 7-23 1947

X

G53700

BALTIMORE CITY HEALTH DEPARTMENT

CWK-109810

CERTIFICATE OF DEATH V 13 B

G53700 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 17-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 11 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 730 N. Mulberry Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Duvall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wilson Duvall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 10-1890

8. AGE: Years 56 | Months 9 | Days 9 | If less than one day ..... hr. ..... min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Holmes
13. Birthplace Virginia

MOTHER
14. Maiden Name Susie Rice
15. Birthplace Virginia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 24-47 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Westport

18 (a) Funeral director Wm Brooks
(b) Address 1763 N. Carey St

19 (a) JUL 24 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH July 19 1947, at 4:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 11 1947 to July 19 1947, and that I last saw her alive on July 19 1947.

Immediate cause of death: Respiratory failure — Duration: 3 da

Due to: Tuberculosis of Lungs — 1½ yr.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph J Bowen Jr M. D.
Address Balto City Hosp Date signed July 20

G53701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 938

G53701 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2013 N Charles St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2013 N Charles St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George W A Carr

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Emma C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 20. 1858

8. AGE: Years 89 | Months 6 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Asst Cable Reconstructor

11. Industry or business

FATHER
12. Name George M Carr
13. Birthplace Va

MOTHER
14. Maiden Name Jane M Carroll
15. Birthplace Md

16 (a) Informant Mrs Emma C Carr
(b) Address 2013 N. Charles St

17 (a) Funeral (Burial, cremation, or removal) (b) Date thereof 7/26/47 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md

18 (a) Funeral director Wilhoyte & Son
(b) Address 1214 E Fayette St

(a) 24 1947 (b) Huntington Williams M.D. Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1947 at 4:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 18 July 1947, to 23 July 1947, and that I last saw him alive on 22 July 1947.

Immediate cause of death: Arteriosclerotic heart disease — Duration: 8 years

Due to: Coronary arteriosclerosis — Duration: unknown

Due to: Generalized Arteriosclerosis — Duration: unknown

Other Conditions: none

(Include pregnancy within 3 months of death)

Date of operation: none

Major findings of operation: none

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Huntington Williams M.D.
Address 2013 N. Charles St Date signed July 24 1947

G53702

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 131a

G53702 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1617 Harlem ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alberta Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Walter Harris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-28-09

8. AGE: Years 38 | Months 5 | Days 24 | If less than one day: hr. min.

9. Birthplace N.C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Peter
13. Birthplace S.C.

MOTHER 14. Maiden Name Luguna Junkins
15. Birthplace S.C.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-24-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 (a) 7-24-1947 (Date rec'd by registrar) (b) Huntington Williams registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-21-1947 at 5:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-18-47 to 7-21-1947. and that I last saw her alive on 7-21-1947

Immediate cause of death: Hypertensive Encephalopathy — Duration: 1 day

Due to: Hypertension — 4 years

Due to: Chronic Glomerulonephritis — 6 years

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Douglas M. Leavell
Address Johns Hopkins Hosp Date signed 25th July 1947

VS 150

X

G53703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12B

G53703
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 17-1
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 535 Camel Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MATTHEW HUNT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years 46 | Months | Days | If less than one day hr. min.

9. Birthplace VA (Town, county, and state)

10. Usual Occupation Junkman

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Maude Faye
(b) Address 535 Camel St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-25-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 (a) 1947 (Date each registrar received certificate) (b) Huntington Williams M.D. (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20, 1947 at 9:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 7/21/47

G5370-1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓61

Registered No. G53701

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 466 WALTON CT.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA HERSON

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col.	Widow

6 (b) Name of husband or wife Robert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/27/[illegible]

8. AGE: Years	Months	Days	If less than one day
59	5	25	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Alexander Banks
13. Birthplace Hagerstown, Md.

MOTHER
14. Maiden Name Isabella Copeland
15. Birthplace Virginia

16 (a) Informant Miss Almeda Banks
(b) Address 466 Walton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 24, 1947 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Ed. J. Holland
(b) Address 1631 Druid Hill Ave

19 (a) 7-24-1947 (Date rec'd by Local Reg'trar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1947, at 8:40 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 1 July 1947 to 21 July 1947 and that I last saw her alive on 21 July 1947.

Immediate cause of death Cardio Respiratory failure — Duration

Due to Toxaemia

Due to Diabetic gangrene left foot

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry T. Wilson Jr. M. D.
Address St. Joseph's Hosp. Date signed 7/21/47

X

G53705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G53705
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2014 Druid Hill
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2014 Druid Hill
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie Alma Kelly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2, 1884

8. AGE: Years	Months	Days	If less than one day
63	1	19	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Teacher

11. Industry or business Public schools

FATHER
12. Name William H. Kelly
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Angeline Brown
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Annie L. Kelly
(b) Address 2014 Druid Hill Ave.

17 (a) Burial (b) Date thereof July 24, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Geo. H. Holland
(b) Address 1631 Druid Hill Ave.

19 JUL 24 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/21/47 19..., at 7:45 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Hypertensive Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis, M.D.
Medical Examiner.
Date signed 7/21/47

G53706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓ G53706 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 762 Carroll St.
(c) Hospital or institution:

21

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 762 Carroll St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES HAMILTON GREENE

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Pearl C. Greene
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13, 1885

8. AGE: Years	Months	Days	If less than one day
62	6	9	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation driver
11. Industry or business York Motors Co.

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mr. Carl H. Greene
(b) Address Rice's Lane, R. F. D. #5

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/26/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 7 24 1947 (Date received by local registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22, 1947, at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1947 to July 22 1947, and that I last saw [illegible] alive on July 21 1947.

	Duration
Immediate cause of death Coronary Artery occlusion	4 hrs.
Due to Arteriosclerosis of Coronary arteries	1 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John P. Uhlenk Jr.
Address 122 Dwight Blvd Date signed 7/23/47

X

G53707

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G53707

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 8-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto City
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1710 N Patterson Pk Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** ANNA DORR

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Walter Dorr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec: 10, 1883

8. AGE: Years	Months	Days	If less than one day
63	7	12	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name John Hetche
13. Birthplace germany

MOTHER
14. Maiden Name Louise Schmidt
15. Birthplace Germany

16 (a) Informant Walter Dorr
(b) Address 1710 N. Patterson Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-26-1947 (month) (day) (year)
(c) Cemetery or crematory Woodlands Memorial Park
Location Taylor Ave

18 (a) Funeral director Leo G. Cook
(b) Address 1201-03 N. Patterson Park Ave

19 (a) JUL 24 1947 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1947 at 8:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-21 1947 to 7-22 1947, and that I last saw her alive on 7-22 1947.

Immediate cause of death Uremia — Duration 2

Due to arteriosclerotic Heart dis

Due to

Other Conditions Pleural Effusion, right, carcinoma (Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John B Brickner M. D.
Address Mercy Hosp Date signed 7-22-47

VS 150

G53708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G53708

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Aves.
(c) Hospital or institution: St. Agnes Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1433 W. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John A. Houston

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-05-1546

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	married

6 (b) Name of husband or wife Rose Houston

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 3, 1881

8. AGE: Years	Months	Days	If less than one day
65	10	19	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Guard

11. Industry or business Walters Art Gallery

FATHER
12. Name John Houston
13. Birthplace Md. Pa.

MOTHER
14. Maiden Name Sarah Schuepbach
15. Birthplace Md.

16 (a) Informant Mrs Rose Houston
(b) Address 1433 W. Balto St

17 (a) Burial (b) Date thereof July 26-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem
Location Woodlawn Md

18 (a) Funeral director Geo E Beyer Jr
(b) Address 1512 Hollins St

19 JUL 24 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/22 1947, at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/21 1947 to 7/22 1947, and that I last saw h im alive on 7/22 1947.

Immediate cause of death	Duration
1 Cardiac Failure	
2 Coronary Thrombosis	
3 Cardiac Tamponade	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur W. Shaw M. D.
Address St. Agnes Hosp. Date signed 7/22

G53709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G53709 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 132 N. Pearl St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4d
(e) Length of stay in Baltimore (yrs., mos., or days) 24yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 132 N. Pearl St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E Allen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ Late James R Allen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 15 1866

8. AGE: Years	Months	Days	If less than one day
81	5	4	hr. min.

9. Birthplace New Jersey (town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs Lawrence K Lines
(b) Address 132 N. Pearl St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof July 24 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Old Frederick Rd

18 (a) Funeral director Harry A Wright
(b) Address 4101 Edmondson Ave

JUL 24 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1947, to July 24 1947 and that I last saw h. alive on July 21 1947

Immediate cause of death

	Duration
Cerebral Hemorrhage	3 days
Due to	
Due to Hypertension	2
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Klaussman M. D.
Address 213 W. Eighth St Date signed July 24 1947

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53710

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

✓ G53710 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2717 (2719) W. Baltimore St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2717 (2719) W. Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Lee Cleaties

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-4968 A

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband ~~or wife~~ Minnie Winfield Cleaties

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3, 1879

8. AGE: Years 68 | Months 1 | Days 19 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name Henry Clay Cleaties
13. Birthplace Md

MOTHER
14. Maiden Name Magdalene Burnham
15. Birthplace Md

16 (a) Informant Mrs Minnie W Cleaties
(b) Address 2717 (2719) W. Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 23 1947 (month) (day) (year)

(c) Cemetery or crematory Baltimore
Location Mt Olive

18 (a) Funeral director Henry H Withe
(b) Address 4101 Edmondson Ave

1911 7-24-1947 Huntington Williams M.D. Registrar
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-22- 1947 at 6:11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 to July 22 1947. and that I last saw him alive on 7-22-1947.

Immediate cause of death Carcinoma Sigmoid — Duration 1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. B. Schreiber M. D.
Address 574 S. Fulton Ave Date signed 7-23-47

X

G53711

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G53711

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33 Sts.
(c) Hospital or institution: Union Memorial

(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 208 South Tyrone Road (If no street give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME FOSTER CRUTCHER (Foster Brandenburg Crutcher)

3 (b) If veteran, name war W.W. 1 & 2

3 (c) Social Security Account No. 218-07-4718

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Virginia B. Crutcher

6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) Sept-16-1892

8. AGE: Years 54 | Months 10 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace Mississippi (Town, county, and state)

10. Usual Occupation Corps Engineers-U.S. Col

11. Industry or business Engineering

FATHER 12. Name —?— Crutcher

FATHER 13. Birthplace Mississippi

MOTHER 14. Maiden Name Miss Dant

MOTHER 15. Birthplace probably Kent Co. Md.

16 (a) Informant Mrs Virginia D. Crutcher

(b) Address 208 Tyrone Rd. Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 26 47 (month) (day) (year)

(c) Cemetery or crematory Lorraine

Location Woodlawn

18 (a) Funeral director Shivers Mort Co,

(b) Address 108 W Mosher Ave.

19 (a) Date rec'd by local registrar 7-24-47 (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/22/47 19____, at 10:10 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to ____

Other Conditions ____

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ____ at ____ M.

(b) Where did injury occur? ____

(c) Did injury occur at home, on farm, industrial place, in public place? ____ While at work? ____

(d) Means of injury ____

23. Signature John R Evans M.D. Medical Examiner

Date signed 7/22/47

G53712

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G53712 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2001 Park Ave
(c) Hospital or institution: (Home) The Taylor 13-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2001 Park Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edna Wilson Taylor

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: none
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Jan 7 1876
8. AGE: Years 71 | Months 6 | Days 16 | If less than one day ____ hr. ____ min.
9. Birthplace Snowhill Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John Wesley Taylor
13. Birthplace Md.

MOTHER
14. Maiden Name Martha Riley
15. Birthplace Md

16 (a) Informant Mrs Robt B Elliott (Sister)
(b) Address Seaford Del.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 25 47 (month) (day) (year)
(c) Cemetery or crematory National Mem.
Location Snowhill Md

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. MOWEN SUC.) 100 N. NORTH AVENUE

JUL 24 1947 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1947, at 10:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1940 to July 23 1947, and that I last saw h[er] alive on July 22 1947.

Immediate cause of death	Duration
Carcinomatosis	1 mo.
Emaciation	6 mos.
Due to Carcinoma of Liver	1 yr.
Cancer of	2 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robt B Elliott M. D.
Address Masonic Auto Bldg Baltimore Md. Date signed 7/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53713 BC# JD - 112007 5-83/47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G53713

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Balto. City Hospts.
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
307 W. Preston St. 11c
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 307 W. Preston St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Thompson- Albreth

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1947

8. AGE: Years	Months	Days	If less than one day
		5	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Floyd Thompson
13. Birthplace N. C.

MOTHER
14. Maiden Name Albreth Malay
15. Birthplace N. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Cremated (b) Date thereof 7-22-47
(Burial, cremation, or removal) (month) (day) (year)
(c) ~~Cemetery or~~ crematory Baltimore City Hospitals
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) JUL 24 1947 (b) Huntington Williams M.D.
(Date rec'd by reg.) (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

AM

20. DATE OF DEATH July 14 1947 19 , at 3.50 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 9, 19 47, to July 14 19 47, and that I last saw h im alive on July 14 19 47.

Immediate cause of death Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy prematurity

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arnold H Becker M.D.
Address Balto City Hosp Date signed 7/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G53714

Registered No.

Med. Exam. Case.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1430 May. Ct. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha LoMax
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female
5. Color or race: black
6 (a) Single, married, widowed, or divorced: widow
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years 42 | Months | Days | If less than one day hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name William Weaver
13. Birthplace

MOTHER 14. Maiden Name ?
15. Birthplace

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/23/47 (month) (day) (year)
(c) Cemetery or crematory [illegible]
Location Virginia

18 (a) Funeral director Elmer Ostelson
(b) Address 1005 Brentford Ave

19 JUL 24 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

C. J. Lubinski MD / G. L. Merrill MD

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1947 at 12:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 2019 47 to July 20 19 47 and that I last saw h[illegible] alive on July 20 1947.

Immediate cause of death: Myocarditis

Duration: 1 hr

Due to: Arteriosclerosis

Due to: diffuse

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Entire heart

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury Carrole

23. Signature [illegible]
Address [illegible] Date signed 7/24/47 M. D.

X

G53715 B2547 Med Exam'r

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157a

Registered No. G53715

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 5-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A M M.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 420 Aisquith St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Collier

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/5/1945

8. AGE: Years 2 | Months 1 | Days 15 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Albert Downham
13. Birthplace Del.

MOTHER
14. Maiden Name Ida Collier
15. Birthplace Baltimore Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-24-47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elmer A. Wilson
(b) Address 1000 Argyle Ave

19 (a) JUL 24 1947 (Date received by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-20-1947, at 6.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-20-1947, to 7-20-1947, and that I last saw her alive on 7-20-1947.

Immediate cause of death	Duration
(a) D.O.A.	
Due to Tubular Pneumonia M.D.M.	
Due to	
Other Conditions Hydrocephalus, Autopsy	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy Encephalitis; as above M.D.M.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry F. Bahnson M.D.
Address J.H.H. Date signed 7-24-47
Dr. Wm. Holfrath by Howard J. Madden M.D. 107

VS 150

G53716 (2)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G53716 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 635 S. Eaton St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Anna Weinknecht

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Deceased Frank Weinknecht

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24, 1881

8. AGE: Years 66 | Months 3 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Trippeter

13. Birthplace Germany

MOTHER 14. Maiden Name Hereca Cantow

15. Birthplace Germany

16 (a) Informant Anna Weinknecht

(b) Address 635 S. Eaton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 28-47 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Location Eastern Blvd.

18 (a) Funeral director Thos. E. Connelly

(b) Address 418 E. Eastern Ave. Balto.

19 JUL 24 1947 (b) (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/23/47 19 , at 3:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/3/47 19 , to 7/23/47 , and that I last saw deceased alive on 7/23/47

Immediate cause of death: Uremia — Duration

Due to: Myocardiosclerosis

Due to: (Left kidney removed)

Other Conditions: Hypertensive Cardio-Vascular disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence , at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph D. Antonis M.D.

Address Church Home & Hosp. Date signed 7/23/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53747 M 12100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G53747

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 14-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2121 Madison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May ? 1895

8. AGE: Years	Months	Days	If less than one day
52	2		hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation maid.

11. Industry or business

FATHER
12. Name Jake Wade
13. Birthplace Va.

MOTHER
14. Maiden Name Adelina Wade
15. Birthplace Va.

16 (a) Informant records- Baltimore City Hospital
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 7/24/47 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location A. A. County

18 (a) Funeral director Kemp Sanderc
(b) Address 1412 E. Preston Ave.

19 JUL 24 1947 (b) Flemington New Jersey (Delivered by undertaker) (Address)

VS f50 4

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1947, at 10:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 12 1947 to July 21 1947 and that I last saw her alive on July 21 1947

Immediate cause of death: Cerebral hemorrhage — Duration 10 day

Due to

Due to

Other Conditions Hypertension Heart Disease yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Unknown

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. C. Robinson Jr. M. D.
Address Balt City Hosp Date signed 7/23/47

83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53718 Howe

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

Registered No. G53718

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Calvert
(c) City or town St. Leonard P.O. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maude Howe

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Fe | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Herbert Howe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/9/98

8. AGE: Years 48 | Months 10 | Days 14 | If less than one day hr. min.

9. Birthplace Calvert Co, Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Andrew Johnson
13. Birthplace Md

MOTHER
14. Maiden Name Mary Anderson
15. Birthplace Md

16 (a) Informant Esa Johnson
(b) Address 1309 Division St Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/22/47 (month) (day) (year)
(c) Cemetery or crematory Brookes Chapel
Location Calvert Co

18 (a) Funeral director P. E. Sewell
(b) Address Prince Frederick Md

JUL 24 1947 (Date received by registrar) (b) [illegible] Huntingtown Williams Md (Registrar)

1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/23 1947, at 8 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/23 1947 to 7/23 1947, and that I last saw h.e.r alive on 7/23 1947.

Immediate cause of death	Duration
Subarachnoid Hemorrhage	10-12-48
Due to Hypertension	
Due to	
Other Conditions Obesity	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Paxton Hart M.D.
Address 15a Division St Date signed 7/25/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~G53719~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. G53719

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1213 Winchester St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clintard BROWN

3 (b) If veteran, name war: W W # 2
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/17/1923

8. AGE: Years	Months	Days	If less than one day
24	5	4	hr. min.

9. Birthplace Columbus Penn
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John Brown
13. Birthplace Columbus Penn

MOTHER
14. Maiden Name Zana Collins
15. Birthplace Jonesburg Penn

16 (a) Informant Garruther Thomas Howard
(b) Address Pontiac Michigan

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/26/47 (month) (day) (year)
(c) Cemetery or crematory Pontiac, Mich
Location Michigan

18 (a) Funeral director Leo A Kelson
(b) Address 1303 Pleasant Ave

19 JUL 24 1947 (Date rec'd) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1947, at 9:30 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet-wound of lungs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-21-47 at 9 P M.
(b) Where did injury occur? Wilkins & McCullough St Restaurant
(c) Did injury occur at home, on farm, industrial place, in public place? Restaurant While at work? No
(d) Means of injury Firearms

23. Signature Geo L Merrill M.D.
Medical Examiner.
Date signed 7/22/47

VS 151

G53720

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G53720

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hospital 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 671 W Barre St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maka Kiwaka or Makary Wasibur Kiwka

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not know

8. AGE: Years	Months	Days	If less than one day
87			hr. min.

9. Birthplace Russian (Town, county, and state)

10. Usual Occupation Retirement

11. Industry or business

FATHER
12. Name Not know
13. Birthplace Russian

MOTHER
14. Maiden Name Not know
15. Birthplace Russian

16 (a) Informant Rev. Gregory H. Pelesh
(b) Address 1725 E. Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 25-47 (month) (day) (year)
(c) Cemetery or crematory Holy Trinity Russian
Location Stoney Run, Md

18 (a) Funeral director John A. Zrebliauskas Jr.
(b) Address 423 S. Paca St

19 JUL 24 1947 (b) (Date received by Registrar) Huntington Williamsport, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1947, at 5:25 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Pulmonary Em

Due to Myocardial Degeneration

Other Conditions Fract. Left Hip - Chronic Cystitis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following: 22/2

(a) Date of injury 7-17-47 at 1:00 A.M.
(b) Where did injury occur? 671 W Barre St
(c) Did injury occur at home, on farm, industrial place, in public place? Home (Rear) While at work? na
(d) Means of injury Fall from front porch
23. Signature Earl K. Ringler M.D.
Medical Examiner
Date signed 7-22-47

G58721 RAINIER G52721

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Franklin Square Hospital
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 32 E. Rendall St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sallie Rainier

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 21 - 1877

8. AGE: Years 69 | Months 9 | Days 3 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Frank Bridges
13. Birthplace Virginia

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant William Rainier
(b) Address same

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 7-21-47 (month) (day) (year)
(c) Cemetery or crematory Matthews Chapel
Location Matthews Co Va

18 (a) Funeral director James L. McCauley
(b) Address 15 S. Fort Ave.

19 (a) JUL 24 1947 Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-23-1947, at 10:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-18 1947 to 7-24 1947.
and that I last saw her alive on 7/23 1947

Immediate cause of death Cerebral Hemorrhage — Duration
Due to Fracture of the base of the skull
Due to Accident
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 23/2
(a) Accident, suicide, or homicide Accident?
(b) Date of occurrence 7-18-47 at ? M.
(c) Where did injury occur? 32 East Rendall St. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fell down stairs

23. Signature Fred Maxwell
Address Franklin Sq Hosp. Date signed 7/24/47
Howard J. Carlson, M.D.

VS 150

G53722

Reserve #9

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

Registered No. G53722

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State D. C. (b) County
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 214 John Marshall Pl (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Oscar Lavender

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY JUL 24 1947

18 (a) Funeral director Commissioner of Health.
(b) Address

19 (a) 7-24-1947 (Date rec'd by Registrar) (Huntington Williams M.D. Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH June 22 1947, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury found: 6-22-47 at 4/1 A. M.
(b) Where did injury occur? Found: Harbor Pier #4 foot 11th.
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? no
(d) Means of injury Found drowned

23. Signature Earl Hoyer M.D. (Medical Examiner.)
Date signed 6-22-47

G53723 Grave #10 ✓ G53723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Found at: Rear of 729 N. Bethel St
(a) State (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME UNKNOWN

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1917

8. AGE: Years	Months	Days	If less than one day
30			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Unknown
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY JUL 24 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JUL 24 1947 (Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH June 20, 1947, at 7 40 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Miliary tuberculosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 6/30/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G53724

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Oregon (b) County
(c) City or town Portland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1263 SW Spring Garden Rd.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Myrtle Gibson Rivers

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife William Rivers

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) August 29, 188[illegible]

8. AGE: Years 57 | Months 10 | Days 23 | If less than one day ... hr. ... min.

9. Birthplace Oregon (Town, county, and state)

10. Usual Occupation Hwf

11. Industry or business

FATHER
12. Name James E. Gibson
13. Birthplace Forest Grove, Oregon

MOTHER
14. Maiden Name Mary Ellen Blidioo
15. Birthplace Forest Grove, Oregon

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7- -47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Balto.

18 (a) Funeral director L. Rick
(b) Address 5305 Harford Rd.

1947 JUL 24 (Date received by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 19 47 at 10:08 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 16 19 47 to July 22 19 47, and that I last saw h or alive on July 22 19 47.

Immediate cause of death (1) Postoperative biliary fistula common bile duct and cholelithiasis
(2) Hepatitis chronic with liver atrophy
Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7-21-47

Major findings of operation: Biliary fistula with stone in common bile duct

of autopsy: As above

Duration
24 HOURS
UNKNOWN

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Glen E. Ogden
Glen E. Ogden, Surgeon M. D.
Address US Marine Hospital Date signed 7/24/47
Balto, 11, Md.

VS 150

G53725

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170C

Registered No. G53725

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 908 Garden Drive- Essex.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE K, CHILTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 17, 1943

8. AGE: Years	Months	Days	If less than one day
3	7 6	6	hr. min.

9. Birthplace Ches Co - Maryland
(Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER
12. Name George R. Chilton
13. Birthplace N. Y.

MOTHER
14. Maiden Name Hilda E. Keller
15. Birthplace Pa.

16 (a) Informant Mr. George R. Chilton
(b) Address 908 Garden Drive, Essex

17 (a) Burial (b) Date thereof 7/25/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory More land Park
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Hanford Road

19 (a) JUL 24 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23, 1947, at 9.45 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Broken neck, Intra-abdominal hemorrhage due to ruptured liver, spleen, and kidney

Due to

Other Conditions multiple bruises

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-23-47 at Balto. Co. 8 p. M.
(b) Where did injury occur? Garden Drive Baltimore, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pediastrian-struck by auto

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 7-24-47

MADCIS

X

G53726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1637

Registered No. G53726

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0aa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 331 Runkert
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ross A MILLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, (widowed), or divorced.

6 (b) Name of husband or wife Jennie L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-10-1883

8. AGE: Years 64 | Months 6 | Days 12 | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Samuel T Miller
13. Birthplace Md

MOTHER 14. Maiden Name Virginia Rapley
15. Birthplace Md

16 (a) Informant James A Miller
(b) Address 331 Runkert on

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-25-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto

18 (a) Funeral director Leonard J Rinck
(b) Address 1205 Bruford Rd

JUL 24 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1947, at 12 30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute mercury poisoning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7/20/47 at 10 P. M.
(b) Where did injury occur? Clifton Park Balto Md
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Ingestion of mercury tabs.

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 7/22/47

VS 151

X

G53727

BCH 84293

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G53727 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lamard & Greene Sts.
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED: Anne Arundel
(a) State Md. (b) County Balto
(c) City or town ~~Balto~~ Patapsco Park
(If outside city or town limits, write RURAL and give town)
(d) Street No. ~~Univ. Hosp.~~
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby girl. Brooks. (Premature infant) Jean Barbara Brooks

3 (b) If veteran, state war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-18-47.

8. AGE: Years	Months	Days	If less than one day
0		5	hr. min.

9. Birthplace University Hosp. (town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name James Eugene Brooks

13. Birthplace Philad, Pa

MOTHER 14. Maiden Name Beulah E. Snowden

15. Birthplace Hanover Md.

16 (a) Informant (From hosp chart)

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School JUL 24 1947

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) JUL 24 1947 (Date received by registrar) Wm. Shaefer Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-23-47 19 , at 4:22 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-18- 1947, to 7-23 1947, and that I last saw h a alive on 7-23 1947.

Immediate cause of death aspiration of food regurgitation of food. | Duration

Due to

Due to

Other Conditions Premature infant.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. R. Hahn M. D.

Address Univ. Hosp Date signed 7-23-47.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. 653728 BCHD-82925

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNION MEMORIAL HOSPITAL 27
(d) Length of stay in hospital or inst. (~~where~~ days) 20
(e) Length of stay in Baltimore (~~where~~ days) 20

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE 12 (If outside city or town limits, write RURAL and give town)
(d) Street No. 816 E. Belvidere Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Trueheart

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4 - 47

8. AGE: Years — | Months — | Days 20 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business —

FATHER 12. Name Herbert Lee Trueheart
13. Birthplace Maryland

MOTHER 14. Maiden Name Helen L. Lakin
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/24/47 (month) (day) (year)
(c) Cemetery or crematory St. Paul, Md.
Location

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Huntingtown Williams M.D. (Date received by Registrar) Registrar

JUL 24 1947

Vs 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1947, at 12 ~~noon~~ M

21. I certify that death occurred on the date above stated; that I attended deceased from July 4 1947 to July 24 1947, and that I last saw ~~him~~ her alive on July 24 1947.

Immediate cause of death: Congenital Heart Disease — Duration: Life

Due to

Due to

Other Conditions Meningocele — Life

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature E. B. Chamberlain M.D.
Address Union Memorial Hosp Date signed 7/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~3729~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. ~~3729~~

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2227 West Pratt St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Anna Robl

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Joseph Robl
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1868

8. AGE: Years	Months	Days	If less than one day
79	3	21	hr. min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Ventzel Tahild
13. Birthplace Austria

MOTHER
14. Maiden Name Theresa ~~F~~
15. Birthplace Austria

16 (a) Informant Mary T. Rozlowski
(b) Address 2227 W. Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-26-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md.

18 (a) Funeral director George L. Schwab
(b) Address 2101 Aisquith Ave

19 (a) (Signature of local registrar) (b) Transmitted for Registration [illegible] Registrar

JUL 25 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1947, at 3:10 p.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 9 1947 to July 23 1947, and that I last saw ~~him~~ her alive on July 23 1947.

Immediate cause of death	Duration
congestive failure	
Due to arteriosclerotic heart disease	
Due to	
Other Conditions diabetes mellitus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: generalized arteriosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert A. Lericha
Address St. Agnes Hospital Date signed 7/25/47

93 D

G53730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

G53730 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1635 Thames St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jose Lopez

3 (b) If veteran, name war --

3 (c) Social Security Account No. 087-12-8388

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 16, 1890

8. AGE: Years	Months	Days	If less than one day
57	4	4	hr. min.

9. Birthplace Spain (Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business Seafarer

FATHER
12. Name Joseph Lopez
13. Birthplace Spain

MOTHER
14. Maiden Name Mandel Suoto
15. Birthplace Spain

16. (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-25-47 (month) (day) (year)
(c) Cemetery or crematory St. Mathai
Location 6104 O'Donell, St.

18 (a) Funeral director Sill & Zeiler, Inc.
(b) Address 403 S. Wolfe, St. Balto.

19 JUL 25 1947 (b) Thaddeus Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20, 1947, at 4:45A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1947 to July 20 1947 and that I last saw him alive on July 20 1947.

Immediate cause of death (1) Calcific stenosis of the mitral valve, marked, aortic valve moderate. (2) Infarcts of right kidney, moderately, old. (3) Hypertrophy of heart. (4) Chronic passive congestion of liver.

Duration: ABOUT SIX YEARS

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. F. van Ackeren, Medical Director D.
Address Medical Officer in Ch Date signed 7/24/47

G53731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G53731

MARGIN RESERVED FOR BINDING. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Bluff. Md. (b) County Balt.
(c) City or town Balt
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4910 Cronson Ave, Balt, Md.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME DENNIS DUVALL WALKER

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	NAE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/16/78

8. AGE: Years	Months	Days	If less than one day
69	5	7	hr. min.

9. Birthplace Washington, D.C.
(Town, county, and state)
10. Usual Occupation RETIRED.
11. Industry or business

FATHER
12. Name John Newland Walker
13. Birthplace Wash, D.C.

MOTHER
14. Maiden Name MARY Louise DUVALL
15. Birthplace Wash, D.C.

16 (a) Informant Miss AMANDA PENNINGTON
(b) Address 4910 Cronson Ave, Balt.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/26/47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Fulton Funeral Inc
(b) Address 1217 L. Pont St

19 JUL 25 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1947, at 10:31 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 18 1947, to July 23 1947, and that I last saw him alive on July 25 1947.

Immediate cause of death	Duration
Hemorrhage Cerebral	6 days.
Due to Hypertension	
Due to Arteriosclerosis	
Other Conditions Hypertension arteriosclerosis first diagnosed	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature John A. Fischer
Address Union Mem Hosp. Date signed 7/22/47 M. D.

83A

G53732

LW 112186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131B ✓

Registered No. G53732

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1115 Wolfe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willie Branch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2-1897 ?

8. AGE: Years 50 ? | Months 4 | Days 19 | If less than one day ____ hr. ____ min.

9. Birthplace N.C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Miles Branch
13. Birthplace N.C.

MOTHER
14. Maiden Name Nancy Norris
15. Birthplace N.C.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/28/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location A. A. County

18 (a) Funeral director Mrs. H. G. Elliott & Son
(b) Address 1129 N. Caroline St

19 (a) JUL 25 1947 (Registrar) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1947, at 11:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1947 to July 21 1947 and that I last saw him alive on July 21 1947

Immediate cause of death Respiratory failure — Duration

Due to Uremia.

Due to Chronic glomerulo nephritis

Other Conditions Obstruction Ureter valve — enterocolitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Ordered.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Kerberg Jr. M.D.

Address Balto City Hosp Date signed July 25 47

X

G53733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131A

G53733 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 436 Moore St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 436 Moore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James E. Dever

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Alma

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1897

8. AGE: Years	Months	Days	If less than one day
49	10	26	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Eugene Dever
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Tunsty
15. Birthplace Mem., Tenn.

16 (a) Informant Carrie Gross-Sister
(b) Address 436 Moore St.

17 (a) Burial (b) Date thereof 7-26-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halsted
(b) Address 918 Druid Hill Ave.

19 (a) 7-23-1947 (b) Registrar Williams
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23, 1947, at 7 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947, to July 23 1947 and that I last saw h— alive on July 23 1947

Immediate Cause of death Cardiac Renal Disease — Duration 3 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. A. Johnson M. D.

Address 2329 Guilford Ave. Date signed July 24 1947

G53734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

139A

G53734

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 308 W. Biddle Street
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Luida Mc Queen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 23, 1924

8. AGE: Years 23 | Months 1 | Days 24 | If less than one day ..... hr. ..... min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Luke McDue
(b) Address 308 W. Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-25-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location.....

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Avenue

19 (a) 5 1947 (Date received by registrar) Huntington Williams M.D. (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21, 1947 at 2 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH.....
Lobar pneumonia

Due to.....

Other Conditions Fat infiltration of liver.
Chronic salpingitis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 7/22/47

108.

G53735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131A

Registered No. G53735

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1709 E Lobaee St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leonard Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	Colored.	married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-10-11

8. AGE: Years	Months	Days	If less than one day
36	3	13	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Long Shoreman
11. Industry or business

FATHER
12. Name Richard Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Lydia Brown
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof July 27/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus M. Park
Location Arbutus Md

18 (a) Funeral director Mrs Robt A Elliott & Son
(b) Address 124 N. Caroline St (b) Huntington Williams, Md.

JUL 25 1947
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July - 23 1947, at Washington

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1947, to July 23 1947, and that I last saw him alive on July 23 1947.

Immediate cause of death	Duration
Cardiac Failure with malignant hypertension	
Due to Hypertensive Encephalopathy	
Due to Chronic arteriolar Nephritis with	
Other Conditions Uremic pericarditis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: 7-24-47- not complete yet

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. H. Sisson M. D.
Address Johns Hopkins Hosp. Date signed 7-24-47

X

G53736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 948

G53736
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2626 Park Heights Terrace
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2626 Park Heights Terrace
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dora Baird

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Abraham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 65 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Hyman
13. Birthplace Russia

MOTHER
14. Maiden Name Dora
15. Birthplace Russia

16 (a) Informant Nathan Baird
(b) Address 2034 E. Dalto St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-25-47 (month) (day) (year)

(c) Cemetery or crematory
Location Hebrew Mt. Carmel

18 (a) Funeral director Jack Lewis Inc
(b) Address 200 Eutaw Place

19 JUL 25 1947 (Date rec'd by Registrar) (b) Huntingtown, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-24-1947, at 11:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1935 to July 23 1947 and that I last saw her alive on July 23 1947

Immediate cause of death: Acute heart failure — Duration: 3 days

Due to: Chr. myocardial Insufficiency — 6 years

Due to: Coronary artery disease Coronary thrombosis in 1941 + 1943 — 2 years

Other Conditions: Auricular Fibrillation

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jacob Cohen M. D.
Address 1804 Eutaw Place Date signed 7/24/47

X

G537737

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G537737

MARGIN RESERVED—FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 933 Sharp
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs.) mos., or days) 6

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 933 Sharp St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Felder Brapton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/15/1890

8. AGE: Years	Months	Days	If less than one day
57	2	8	hr. min.

9. Birthplace Manning S. C (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name William Bronson
13. Birthplace S. C

MOTHER
14. Maiden Name Angeline Bennett
15. Birthplace S. C

16 (a) Informant William Felder
(b) Address 711 Appleton St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7/ 1 /47 (month) (day) (year)
(c) Cemetery or crematory Manning
Location S C

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 1028 W Montgomery St

19 JUL 25 1947 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1947, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1947 to July 23 1947, and that I last saw h[er] alive on July 21, 1947

Immediate cause of death Lobar Pneumonia — Duration 3 days

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John W. Gaines M. D.
Address 50 W. Hamburg St Date signed 7/24/47

VS 150

C53738

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. C53738

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2028 Mt. Royal Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harriette H. Brickman

3 (b) If veteran, name war

3 (c) Social Security Account No.

Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-31-1860

8. AGE: Years	Months	Days	If less than one day
86	8	22	hr. min.

9. Birthplace Balto., Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Rev. Arthur V. Brickman
13. Birthplace Germany

MOTHER
14. Maiden Name Susan Spangler
15. Birthplace Germany

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 7/26/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (Date rec'd by registrar) JUL 25 1947 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23, 1947, at 2:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 13 1947 to July 23 1947 and that I last saw h. alive on July 23 1947.

Immediate cause of death	Duration
Cardiac Failure.	5 days
Due to Pneumonia.	
Due to Debility.	
Other Conditions Colles fracture Left.	

(Include pregnancy within 3 months of death)

Date of operation Closed Reduction 14 July 47

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 7/13/47 12-2
(c) Where did injury occur? Balto. Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Fell striking on floor

23. Signature Isabel A. Edgeworth M.D.
Address Johns Hopkins Hosp. Date signed 29 July 47

7/25 approved Howard J. Moreschi, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53739

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94B

Registered No. G53739

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3017 Wylie Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3017 Wylie Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES HUTSON WHITE

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Florence E. White
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15, ~~1872~~ 1872

8. AGE: Years	Months	Days	If less than one day
75 (76)	6	9	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Billing Clerk
11. Industry or business Daniel Miller & Co.

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Florence E. White
(b) Address 3017 Wylie Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/26/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUL 25 1947 (Date rec'd by registrar) (b) Huntington Wilkinson, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24, 1947, at 3:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 9 1947, to July 24 1947 and that I last saw h[illegible] alive on July 24 1947.

Immediate cause of death	Duration
(a) Coming Thrombosis	7/9/47
Due to Arteriosclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hugh D. Bubert M. D.
Address 20 S. Paul St. Date signed 7/25/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

653740

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

653740

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3413 Carlisle Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Edward T. Broll

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Elizabeth Ann Broll
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9, 1887

8. AGE: Years	Months	Days	If less than one day
60	1	15	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Butcher

FATHER
12. Name Henry Broll
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Katherine Gettier
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Elizabeth A. Broll wife
(b) Address 3413 Carlisle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/28/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUL 25 1947 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1947, at 10 40 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Geo. G. Merrill M.D. Medical Examiner.
Date signed 7/24/47

G55741

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

Registered No. G55741

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTO.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Falls Rd. Mt. Washington
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME P. Carroll Tormey.

3 (b) If veteran, name war	3 (c) Social Security Account No.
-none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Lillian B. Tormey (nee Hevell) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19, 1876

8. AGE: Years	Months	Days	If less than one day
71	0	5	hr. min.

9. Birthplace Baltimore Co.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank A. Tormey
13. Birthplace Unknown

MOTHER
14. Maiden Name Virginia Rowe
15. Birthplace Unknown

16 (a) Informant Mr. George T. Tormey
(b) Address Falls Rd., Mt. Washington

17 (a) Burial (b) Date thereof 7/28/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19. (a) JUL 25 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1947, at 4:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 1947, to 7-24 1947, and that I last saw him alive on 7-24 1947.

Immediate cause of death	Duration
Circulatory Collapse	
Due to Acute Myocardial Infarction	
Due to Coronary Thrombosis	
Other Conditions Multiple Cerebral & Brain Stem Infarcts.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Sent as above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sidney H. Cochs M. D.
Address University Hospital Date signed 7-24-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C53742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. C53742

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1751 Darley Ave.,
(c) Hospital or institution: Daughters Home,
(d) Length of stay in hospital or inst. (yrs., mos., or days) 42 dys.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5207 Beaufort Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie McComb,

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife Samuel C. McComb,
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1,1866

8. AGE: Years 80 | Months 10 | Days 22 | If less than one day ____hr. ____min.

9. Birthplace Baltimore City,
(Town, county, and state)

10. Usual Occupation Housewife,

11. Industry or business at home,

FATHER
12. Name Peter Hollghhan,
13. Birthplace Ireland,

MOTHER
14. Maiden Name Annie Finnegan,
15. Birthplace Ireland.

16 (a) Informant Mrs. Mary E. Finnegan,
(b) Address 5207 Beaufort Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/25/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore City,

18 (a) Funeral director C. Vernon Lemmon.
(b) Address 4611 Park Heights Ave.

19 (a) JUL 25 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/2 19__, to 7/21 1947, and that I last saw her alive on 7/21 1947.

Immediate cause of death Acute Cerebral Hemorrhage

Due to General arterio sclerosis

Due to ch. myocarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. L. Bornstein M. D.
Address 733 Asquith St. Date signed 7/24/47

V S 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

653743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

✓ 653743 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution:
Mercy Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County 4
(c) City or town Baltimore, Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2113 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Cecelia McGuire Wilson

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Capt. Paul W. Wilson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 6, 1887

8. AGE: Years 60 | Months 6 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business at home

FATHER
12. Name Luke P. McGuire
13. Birthplace Ireland

MOTHER
14. Maiden Name Beatrice Ann Connor
15. Birthplace Ireland

16 (a) Informant Miss Jane C. Wilson
(b) Address 2113 N. Calvert St.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 7/26/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral,
Location Baltimore City,

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

19 JUL 25 1947 (Date rec'd by registrar) Registrar Huntington Williams M.D.

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1947, at 3:18 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947 to July 22 1947, and that I last saw her alive on July 22 1947.

Immediate cause of death Cirrhosis of the liver — Duration

Due to

Due to

Other Conditions Uremia, pneumonia & septicemia

(Include pregnancy within 3 months of death)

Date of operation Insertion of button for ascites, July 14, 1947

Major findings of operation: Normal liver

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert J. Johnson M. D.
Address Mercy Hospital Date signed 7/23/47

X

(P) 5744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

P3A

Registered No. C55744

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert Sts.

(c) Hospital or institution: UNION MEMORIAL HOSP.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County BALTO.

(c) City or town RURAL - CATONSVILLE, MD. (If outside city or town limits, write RURAL and give town)

(d) Street No. 206 SHADY-NOOK COURT (If rural give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3 (a) FULL NAME ETHEL IRENE DORSEY

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: FEMALE

5. Color or race: W

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: MR. HOWARD DORSEY

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/30/88

8. AGE: Years 59 Months 06 Days 25 If less than one day hr. min.

9. Birthplace MARYLAND, BALTIMORE (Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business —

FATHER 12. Name HARRY WILLIAMSON

FATHER 13. Birthplace BALTO, MD.

MOTHER 14. Maiden Name ESTHEL SHELLERS

MOTHER 15. Birthplace BALTO, MD.

16 (a) Informant HUSBAND

(b) Address CATONSVILLE, MD

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-26-47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore MD

18 (a) Funeral director Geo. A. Farley

(b) Address Fulton & Fayette

19 (a) 7-25-1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1947, at 4 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1947 to July 24 1947, and that I last saw her alive on July 23 1947.

Immediate cause of death RUPTURED CEREBRAL ANEURISM

Due to ANOLOMY OF VESSEL WALL.

Due to

Other Conditions DIABETES MELLITUS

(Include pregnancy within 3 months of death)

Date of operation 7/21/47

Major findings of operation: CEREBRAL HEMORRHAGE FROM RUPT. ANEU

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John F. Hogan Jr. M. D.

Address Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C53715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. C53715

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 402 N. Patterson Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine ROCK (Catherine J. Rock)

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ---

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Wm. C. Rock

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 27, 1883

8. AGE: Years 64 | Months 2 | Days 28 | If less than one day ____ hr. ____ min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual Occupation: none

11. Industry or business

FATHER
12. Name: Charles Bandell
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: Catherine ---
15. Birthplace: Balto. Md.

16 (a) Informant: Mrs. Marie Silk
(b) Address: 3323 E. Monument St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 28/47 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cem.
Location: Balto. Md.

18 (a) Funeral director: Philip Henwig Sons
(b) Address: 2024 Orleans St.

19 JUL 25 1947 (Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-18 1947 to 7-23 1947 and that I last saw h. alive on 7-23 1947

Immediate cause of death: Pulmonary edema — Duration: 3 days

Due to: Myocardial insuff. + Hypertension

Due to: Arteriolar nephrosclerosis ? Hrs.

Other Conditions: Chronic Tuberculosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Arteriolar nephrosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: E. S. Westpfal M.D.

Address: Sinai Hosp Date signed 7/24/47

131A

G53716 ✓ G53716

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5115 Maple Park Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5115 Maple Park AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James F. Migan, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Mary Frances Migan

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1864.

8. AGE: Years 82 | Months 8 | Days 20 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John Migan
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Migan
15. Birthplace Ireland

16 (a) Informant Mrs. Richard O'Neill,
(b) Address 5115 Maple Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 26/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd.

18 (a) Funeral director Harry A. Kutzke
(b) Address 4101 Edmondson Ave.

19 (a) JUL 25 1947 Entered by registrar Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23/47. 19 , at 9 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 17/47 19 , to July 23 1947, and that I last saw him alive on July 2 1947

Immediate cause of death: myocarditis — Duration 3 mo

Due to advanced arteriosclerosis — Duration 7

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry A. Kutzke M. D.
Address 2220 Harrison Blvd Date signed July 24/47

G53717

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

G53717 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dan
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 N Eden Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country Port Brazil

3 (a) FULL NAME John Lopes Floris

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-14-3813

4. Sex Male | **5. Color or race** Colored | **6 (a) Single, married, widowed, or divorced.** MARRIED

6 (b) Name of husband or wife MAMIE (Mary B)

6 (c) If alive, give age 2 years

7. Birth date of deceased (mo., day, yr.) October 15 1886

8. AGE: Years 60 | Months 9 | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace Cape Verde Island, Portugal (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Fibre Packing Co.

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Phillips ?
15. Birthplace Cape Verde Island, Portugal

16 (a) Informant Mamie Floris (Mary B.)
(b) Address 1006 N Eden Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 28 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Cherney
Location

18 (a) Funeral director Robert L. Young
(b) Address 1216 W. Cardenas St.

19 JUL 25 1947 (Date rec'd by registrar) Beatrice Williams, Mar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24, 1947, at 1 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary artery disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? ____ While at work?
(d) Means of injury

23. Signature Earl K. Royer M.D. Medical Examiner

Date signed 7-25-47

VS 181

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G52748 B4 B84265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160A

Registered No. G52748

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~Virginia Hosp~~
(c) Hospital or institution: Sinai Hosp. ~~of~~

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1515 N. Duke[illegible] (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Infant of Mildred E. & Earnest Rapp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23-47

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Earnest Rapp
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mildred E. Gumzleman
15. Birthplace Balto. Md.

16 (a) Informant Earnest Rapp
(b) Address 1515 N. Duke[illegible]

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 25-47 (month) (day) (year)

(c) Cemetery or crematory Balto. Lem.
Location North Ave. + Gay St.

18 (a) Funeral director John L. Miller
(b) Address 1[illegible] Jefferson St.

19 (a) JUL 25 1947 (b)
(Date rec'd by registrar) (Huntington Station, Md.)

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/24 19 47 at 1.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/23 1947 to 7/24 1947 and that I last saw h[illegible] alive on 7/24 1947.

Immediate cause of death	Duration
Resp. Failure	
Due to Intracranial Hemorrhage	1 Day
Due to	
Other Conditions Prematurity	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
Intracranial Hemorrhage
of autopsy Prematurity

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Sinai Hospital Date signed 7/24/47

X

G53749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

Registered No. G53749

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3403 Richmond Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY ANDERSON

3 (b) If veteran, name war

3 (c) Social Security Account No. [redacted]

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary Elizabeth Anderson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22-1913

8. AGE: Years	Months	Days	If less than one day
33	10	2	hr. min.

9. Birthplace Boston, Mass.
(Town, county, and state)

10. Usual Occupation Sea Captain

11. Industry or business

FATHER
12. Name Peter O. Anderson
13. Birthplace Sweden

MOTHER
14. Maiden Name Clara W. Anderson
15. Birthplace Sweden

16 (a) Informant Mary Elizabeth [redacted]
(b) Address 3403 Richmond Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 26/47 (month) (day) (year)

(c) Cemetery or crematory Evergreen Cem.
Location Commonwealth Ave. Boston, Mass.

18 (a) Funeral director John A. Miller
(b) Address 2704 Jefferson St.

19 JUL 25 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24, 1947, at 8.26 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet-wound of liver
Abdominal hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-24-47 at 12.40 a. M.
(b) Where did injury occur? Gay & Balto. St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearms

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 7-24-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REMOVE RESERVED FOR BINDING

G53750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G53750

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1025 Fulton Ave (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. Alonzo Taylor
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ada Taylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/25/1889

8. AGE: Years 58 | Months 1 | Days 0 | If less than one day hr. min.

9. Birthplace Lucky Mt Va. (Town, county and state)

10. Usual Occupation Minister

11. Industry or business

FATHER
12. Name Wesley Taylor
13. Birthplace Franklin Co. Va.

MOTHER
14. Maiden Name Mary Taylor
15. Birthplace Franklin Co. Va.

16 (a) Informant Mrs. Ada H. Taylor
(b) Address 1025 Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 27, 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Chas. H. Holland
(b) Address 1631 Druid Hill Ave

19 Filed JUL 25 1947 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/25 1947 at 12.40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 29 1947 to July 25 1947 and that I last saw h.e. alive on July 25 1947.

Immediate cause of death Uremia — Duration 11 Days

Due to Toxic Nephritis

Due to Lobar Pneumonia

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Williams Garner M. D.
Address 151 N Division St Date signed 7/26/47

VS 150

G53751

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194B

Registered No. G53751

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 224 N. Calhoun Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN H. MORSELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1879

8. AGE: Years 68 | Months | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name John Morsell
13. Birthplace Calvert Co. Md.

MOTHER
14. Maiden Name Eliza A. King
15. Birthplace Anne A. Co. Md.

16 (a) Informant William J. Morsell
(b) Address 9515 Indiana Ave. Chicago, Ill.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 26, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Geo. A. Hallan
(b) Address 1627 Druid Hill Ave

19 (a) JUL 25 1947 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22, 1947, at 10.25 a.m.

21. I certify that I took charge of the remains described above, held an ~~autopsy~~ Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Artery Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 7-22-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53752

B 84213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160 A

Registered No. G53752

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette and Calhoun Sts.
(c) Hospital or institution: Franklin Square Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name of county)
(d) Street No. 3000 Fayette Calhoun Sts. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 3000 Balto

3 (a) FULL NAME Baby Girl Linda Rose Maese

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Infant

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21 1947

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name	Wakeland Revere Marshall
FATHER 13. Birthplace	Baltimore Maryland
MOTHER 14. Maiden Name	Mary Jayne Bremner
MOTHER 15. Birthplace	Baltimore Maryland

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 (a) (Date rec'd by Registrar) (Signature of Registrar)

JUL 25 1947
University Medical School
JUL 25 1947
Commissioner of Health
Christopher Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1947 at 8 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1947 to July 23 1947 and that I last saw him alive on July 23 1947

Immediate cause of death	Duration
Anoxia	
Due to Intracranial hemorrhage	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation Intracranial hemorrhage
of autopsy Left hemisphere

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. P. Brinkhorst, M.D.
Address 3 Franklin Square Hosp. Date signed 7/24/47

VS 150

G53753

CWK-106428

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G53753 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 81 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 144 N. Exeter Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Beaver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 14-1865

8. AGE: Years	Months	Days	If less than one day
81	11	5	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Isaac Beaver
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth
15. Birthplace Germany

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JUL 25 1947

18 (a) Funeral director Commissioner of Health
(b) Address Huntington Williams M.D.
(c) (Date received) (Registrar)

JL 25 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1947, at 9:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 13 1947, to July 19 1947 and that I last saw h. er alive on July 19 1947.

Immediate cause of death	Duration
Arteriosclerotic C.V.D.	yrs.
Due to	
Due to	
Other Conditions Senility	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edmunds Baetjer M. D.
Address Balto City Hosp Date signed July 24 1947

X

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53754

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1317

G53754 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2702 Lyndhurst Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2702 Lyndhurst Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elisha Irvington Cox

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: M
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 19 1879
8. AGE: Years 68 | Months 0 | Days 6 | If less than one day ... hr. ... min.
9. Birthplace Balto. Co.
(Town, county, and state)
10. Usual Occupation Stone mason
11. Industry or business Retired

FATHER
12. Name Oliver Wesley Cox
13. Birthplace Balto. Co.

MOTHER
14. Maiden Name Sara Wilhelm
15. Birthplace Balto. Co.

16 (a) Informant Mrs. Nellie Mayo
(b) Address 2843 Bramble Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 27/47 (month) (day) (year)
(c) Cemetery or crematory Forest
Location Balto Co Md

18 (a) Funeral director Edw C Tipton
(b) Address Hampstead Md

19 (a) Registrar Washington Williams, M.D.

JUL 25 1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1947, at 8 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1946, to July 25 1947, and that I last saw ... alive on July ... 1947.

Immediate cause of death

Due to Chr. Myocarditis

Due to Chr. Glomerulitis

Other Conditions Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
1945
1945

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place)
While at work?
(e) Means of injury

23. Signature Dave Dorsey
Address 1663 W North Ave. Date signed 7/26/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G53755 — BALTIMORE CITY HEALTH DEPARTMENT — 1949 — Registered No. G53755

CERTIFICATE OF DEATH — HEBREW FRIENDSHIP CEMETERY.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp. 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2002 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac Fernheimer

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife: Henrietta Fernheimer
6 (c) If dead, give date years
7. Birth date of deceased (mo., day, yr.) July 15 1862
8. AGE: Years 85 Months 0 Days 3 If less than one day hr. min.
9. Birthplace (Town, county, and state)
10. Usual Occupation Butcher
11. Industry or business

MOTHER / FATHER
12. Name Samuel Fernheimer
13. Birthplace Germany
14. Maiden Name Elizabeth Frew
15. Birthplace Germany

16 (a) Informant Mrs Clara Fernheimer
(b) Address Sinai Hospital
17 (a) Burial (b) Date thereof July 27
(Burial, cremation, or removal) (Month) (day) (year)
(c) Cemetery or crematory Shaarei Zedek
Location Balto County
18 (a) Funeral director
(b) Address
19 (a) JUL 25 1947 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/24 1947, at 2:22 PM
21. I certify that death occurred on the date above stated; that I attended deceased from 7/22 1947 to 7/24 1947 and that I last saw him alive on 7/24 1947.

Immediate cause of death: Myocardial failure — Duration
Due to
Due to
Other Conditions: Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Myocardial failure, Arteriosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Herman Manus M. D.
Address Sinai Hosp Date signed 7/24/47

Huntington Williams, MD

949

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53756

BALTIMORE CITY HEALTH DEPARTMENT 1319

CERTIFICATE OF DEATH

Registered G53756

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1116 S Clinton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1116 S Clinton St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie Moeller

3 (b) If veteran, name war —
3 (c) Social Security Account No. [illegible]

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: George
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 25 1856
8. AGE: Years 90 Months 11 Days 0 If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John A Hunters
13. Birthplace Md

MOTHER
14. Maiden Name Wilhelmina Heidner
15. Birthplace Md

16 (a) Informant Mrs M S Baer
(b) Address 5536 Frederick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-28-47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Md
Location Baltimore Md

18 (a) Funeral director Wilson Col Inc
(b) Address 1317 N Carey St

19 (a) JUL 29 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1947, at 11:15 M

21. I certify that death occurred on the date above stated, that I attended deceased from July 1947 to July 25 1947, and that I last saw him alive on July 25 1947.

Immediate cause of death: Cerebral Embolism

Due to: Chronic Myocarditis

Due to: Chronic Interstitial Nephritis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dwight L Hunters, M.D.
Address 2332 Eutaw St Date signed 7-29-47

X

G53757

BALTIMORE CITY HEALTH DEPARTMENT 46F

CERTIFICATE OF DEATH

Registered G53757

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
SOUTH AFRICA
(a) State ..... (b) County .....
(c) City or town E. London
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3 Ryan's Lane
(If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country England

3 (a) FULL NAME Thomas Broughton

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife -- 6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 2, 1908

8. AGE: Years	Months	Days	If less than one day
39	3	23	..... hr. ..... min.

9. Birthplace South Africa
(Town, county, and state)
10. Usual Occupation AB seaman
11. Industry or business Seafarer

FATHER
12. Name Wm. Broughton
13. Birthplace England

MOTHER
14. Maiden Name Alice
15. Birthplace England

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/26/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Wyndhurst Md
18 (a) Funeral director Wilson Corp Inc
Address 1947 St Paul
19 (a) JUL 26 1947 (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1947, at 10:45AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1947 to July 25 1947 and that I last saw him alive on July 25 1947.

Immediate cause of death (primary)	Duration
Carcinoma of liver	UNKNOWN
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Fred van Ackeren, Medical Director
Address Medical Officer in Charge Date signed 7/25/47

VS 130

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53758 Happel 46F

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered G53758

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3439 Harwell Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 77 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3439 Harwell Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary M. Happel

3 (b) If veteran, name war N | 3 (c) Social Security Account No. None

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 8 1869

8. AGE: Years 77 | Months 11 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Ferdinand Hepding

13. Birthplace Baltimore, Md

MOTHER 14. Maiden Name Emma Rhine

15. Birthplace Germany

16 (a) Informant Lillian Happel

(b) Address 3439 Harwell Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/28/47 (month) (day) (year)

(c) Cemetery or crematory Most Holy Redeemer

Location Baltimore, Md

18 (a) Funeral director Wm. Cook, Inc.

Address 6 E. Paul Street

19 (a) JUL 26 1947 (Date rec'd by registrar) Burial for Williamsport, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1947 at 10.00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 11 1947 to July 24 1947 and that I last saw h alive on July 24 1947

Immediate cause of death	Duration
Cardio-respir. failure	
Due to Prostatic Carcinoma	
Biliary System	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur Owen M. D.

Address 610 Montpelier St Date signed 7/24/47

V S 150

G53759 14

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 123

Registered No. G53759

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 440 Whitridge Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sally Burton

3 (b) If veteran, name war	3 (c) Social Security Account No.
N	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-? 13

8. AGE: Years	Months	Days	If less than one day
64?			hr. min.

9. Birthplace ? Baltimore Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name ? Wilhom J Burton
13. Birthplace ? Baltimore Md

MOTHER
14. Maiden Name Agnes Ryby
15. Birthplace Virginia Va

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/28/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem
Location Baltimore Co Md

18 (a) Funeral director Wilhom J Burton Sr
(b) Address 1217 S Paca St

19 JUL 26 1947 (Date rec'd by registrar) Huntington Williams Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1947, at 7.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-16 1947, to 7-25- 1947, and that I last saw her alive on 7-25- 1947

Immediate cause of death	Duration
Arteriosclerotic Heart Dis	?
Due to	
Due to	
Other Conditions Auricular Fibrillation Uremia, Gen Arteriosclerosis	?

(Include pregnancy within 3 months of death)
Date of operation 24 July 1947
Major findings of operation: Inflammatory induration retroperitoneal
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Lawrence Lee Jr M. D.
Address Balt City Hosp Date signed 7-25-47

1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53760 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G53760

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days) 27 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTO
(c) City or town Cockeysville Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. Masonic Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Martha Spence

3 (b) If veteran, name war	3 (c) Social Security Account No.
— W	— NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband ~~of wife~~ ? Spence
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?July 17, 1870

8. AGE: Years	Months	Days	If less than one day
77 ??	0	6	hr. min.

9. Birthplace ? Orangeville, Canada
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ? Robert Keys
13. Birthplace Canada

MOTHER
14. Maiden Name ? Sarah Hewitt
15. Birthplace Canads

16 (a) Informant Mrs. Hays
(b) Address Masonic Home

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 28 (month) (day) (year)
(c) Cemetery or crematory Stone Chapel
Location Stone Chapel Cemetery

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 JUL 26 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 July 1947, at 9¾ A M

21. I certify that death occurred on the date above stated; that I attended deceased from 29 June 1947, to 25 July 1947, and that I last saw h[er] alive on 25 July 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to Arteriosclerotic heart disease	
Due to	
Other Conditions Fracture left humerus	

(Include pregnancy within 3 months of death)
Date of operation 0
Major findings of operation: 0
of autopsy: 0

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 6-25-47 at 5:30 P M
(c) Where did injury occur? Masonic Home, Cockeysville
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public Place While at work? no
(Specify type of place)
(e) Means of injury Fell down steps

23. Signature Howard J. Mullin, M.D.
Address West Balt. Gen. Hosp. Date signed 25 July 47

G53761 DLH. 9384698 BALTIMORE CITY HEALTH DEPARTMENT Registered No. G53761

CWK-112332 CERTIFICATE OF DEATH 159

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 11-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 155 Enon Street Z-17
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Anderson, Martha

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21-1947

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Paul Brown Anderson
13. Birthplace Virginia

MOTHER
14. Maiden Name Martha Lindsay
15. Birthplace Virginia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 7-25-47 (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 JUL 26 1947 (Date accepted by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH July 23 1947, at 4:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1947 to July 23 1947, and that I last saw him alive on July 23 1947.

Immediate cause of death Prematurity	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Asphyxia Prematurity; Prematurity

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arnold H Becker M.D.
Address Balto City Hosp. Date signed 7/28/47

VS 150

G53762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G53762 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address.....

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days).....

(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:

(a) State N. J. (b) County.....

(c) City or town New Brunswick (If outside city or town limits, write RURAL and give town)

(d) Street No. 193 Comstock (If rural give location)

(e) Citizen of foreign country?.....(Yes or No)

If yes, name country.....

3 (a) FULL NAME Henry Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-15-85

8. AGE:	Years	Months	Days	If less than one day
	61	11	10	.....hr. .....min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER

12. Name William Jackson

13. Birthplace Md

MOTHER

14. Maiden Name Rose Dent

15. Birthplace Md

16 (a) Informant Record

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-31-47 (month) (day) (year)

(c) Cemetery or crematory.....

Location New Brunswick, N. J.

18 (a) Funeral director Mrs. Frances A. Hemsley

(b) Address 578 W. Biddle St.

19 (a) JUL 26 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1947 at 1:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 30 1947 to July 25 1947 and that I last saw him alive on July 25 1947

Immediate cause of death	Duration
Respiratory Failure	
Due to Pulmonary Tuberculosis	4 mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide.....

(b) Date of occurrence..... at..... M

(c) Where did injury occur?..... (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)

(e) Means of injury.....

23. Signature J. B. Grisson M.D.

Address Johns Hopkins Hosp. Date signed 25 Jul 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C53763

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C53763

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1602 W Fumbard St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimo
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 W. Fumbard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wladyslaw Smilkowski

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Frances

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26 - 1864

8. AGE: Years 83 | Months 11 | Days 29 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Michael Smilkowski
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace Poland

16 (a) Informant Vera Mathson
(b) Address 1602 W. Fumbard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 29/47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozarowski
(b) Address 1930 Eastern Ave

19 (a) JUL 26 10 (Date rec'd by registrar) Huntington Williams

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25-47 19 at 12:15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 7 1947 to July 25 1947 and that I last saw h. l. alive on July 25 1947

Immediate cause of death: Generalized arteriosclerosis — Duration ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Callery M. D.
Address 1324 Fredericks Ave Date signed 7/28/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53764

LW 112004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G53764

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. no home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Randolph Lambert

3 (b) If veteran, name war

3 (c) Social Security Account No. 12-09-6338

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. seperated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15- 1913

8. AGE: Years 33 | Months 10 | Days 6 | If less than one day hr. min.

9. Birthplace Ga. (Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business

FATHER
12. Name Remus Lambert
13. Birthplace Ga.

MOTHER
14. Maiden Name Edna Magnea
15. Birthplace Ala.

16 (a) Informant Records Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 28 47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A.A. Co Md

18 (a) Funeral director Isaac L. Brown Jr
(b) Address 458 W Monty ommery Street

19 JUL 26 1947 (Date Rec'd by Registrar) (c) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21-1947 19 , at 4:45p M

21. I certify that death occurred on the date above stated; that I attended deceased from July 8 1947, to July 21 1947, and that I last saw him alive on July 21 1947.

	Duration
Immediate cause of death: Respiratory failure	2 da
Due to: Tuberculous meningitis	2 Wk
Due to: Tuberculosis of lungs	2 mo.
Other Conditions: Positive Serology —	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph J Brown Jr M. D.
Address Bal. City Hosp. Date signed 7-22-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Q53765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

Registered No. Q53765

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1613 E. 33rd St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1613 E. 33rd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Edward W. Weitzel Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Kathryn Weitzel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7-1884

8. AGE: Years	Months	Days	If less than one day
62	7	18	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Garage Prop.
11. Industry or business

FATHER
12. Name John Weitzel
13. Birthplace Germany

MOTHER
14. Maiden Name Christina Gross
15. Birthplace France

16 (a) Informant Kathryn Weitzel
(b) Address 1613 E. 33rd St

17 (a) Burial (b) Date thereof July 29-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director John A. Miller
(b) Address 2334 Jefferson St.

19 (a) (b)
(Date received by local registrar) Huntington Williams M.D.

JUL 26 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/25th 1947, at 5:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/24th 1947, to 7/25th 1947, and that I last saw h[illegible] alive on 7/25th 1947.

Immediate cause of death	Duration
Coronary thrombosis	30 hours
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature N. J. Jenkins M. D.
Address 180 N. Mullowney Date signed 7/26/47

X

G53766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓93E

Registered No. G53766

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey St.
(c) Hospital or institution: Good Samaritan Com Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 714 W. 34th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura E. Frederick.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: George Frederick.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1871

8. AGE: Years 76 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Anna L. Ruley.
(b) Address 821 W. 33rd St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 27 1947 (month) (day) (year)
(c) Cemetery or crematory Poplar
Location Balto Co.

18 (a) Funeral director Schenawith & Sons
(b) Address 3645-47 Belmont Ave.

19 (a) JUL 26 1947 (Date rec'd by registrar) Huntington Williamson, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1947, at 5:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 21 July 1947, to July 24 1947, and that I last saw h.m. alive on 24 July 1947

	Duration
Immediate cause of death: Acute cardiac dilatation	2 days
Due to: Myocarditis	Unk.
Due to:	
Other Conditions: Marasmus - Partial intestinal obstruction.	2 days.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles Cammarella M.D.
M. D.

Address 910 W. Lombard Date signed 25 July 47.

053767

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83 A

Registered No. 053767

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1313 Chapel St
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1313 N. Chapel St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Minnie Mack Brown

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife Deceased
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 6, 1887

8. AGE: Years	Months	Days	If less than one day
60	5	17	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Albert Mack
(b) Address 1206 Llewellyn Ave

17 (a) Burial (b) Date thereof July 26 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location G. A. Counter

18 (a) Funeral director Mrs. A. P. Hawkins Sr.
(b) Address 4 N. Caroline St

JUL 26 1947

19 (a) (Date rec'd by registrar) (b) Huntington Williamson, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-23 1947, at 5:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-21 1947 to 7-23 1947 and that I last saw her alive on 7-21 1947.

Immediate cause of death	Duration
Apoplexy	2 days
Due to Hypertension	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. W. McDaniel M. D.
Address 817 N. Caroline St Date signed 7-24-47

X

G53768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 948

Registered No. G53768

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: City Jail V. 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State S.C. (b) County.....
(c) City or town Charlotte (If outside city or town limits, write RURAL and give town)
(d) Street No. 162 E. Cannon St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Joseph J Nettles

3 (b) If veteran, name war ?
3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 12-1911

8. AGE: Years	Months	Days	If less than one day
35	11	11	..... hr. ..... min.

9. Birthplace Charlestown South Carolina (Town, county, and state)
10. Usual Occupation Plumber
11. Industry or business

FATHER
12. Name Gadsden Nettles
13. Birthplace Summerville S. C.

MOTHER
14. Maiden Name Hattie Bradwell
15. Birthplace Orangeburg S. C.

16 (a) Informant Mr Clide J. Nettles
(b) Address 162 E. Cannon St. Charlestown S.C.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 7-26-47 (month) (day) (year)
(c) Cemetery or crematory Bethany
Location Charlestown S. C.

18 (a) Funeral director Wm J. Tickner & Sons
(b) Address N. & Pd. Aves Balto Md.

19 (a) JUL 26 1947 (Date rec'd by registrar) Turnington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/23 1947, at 5 o. P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature [signature] M.D. Medical Examiner.
Date signed.....

Q53769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83A

Register No. Q53769

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 201 Dolphin st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	N	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
68 9			hr. min.

9. Birthplace St. Mary's Co. Md (Town, county, and state)

10. Usual Occupation domestic

11. Industry or business

FATHER
12. Name Thomas Jones
13. Birthplace Md

MOTHER
14. Maiden Name — Lee
15. Birthplace Md

16 (a) Informant Robert G. Smith
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/28/47 (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location Md

18 (a) Funeral director Geo. B. Kelson
(b) Address JUL 26 1947 Pulaski Hwy

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/25 1947, at 4:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/21 1947 to 7/25 1947, and that I last saw h.. alive on 7/25 1947.

Immediate cause of death Subarachnoid Hemorrhage — Duration 3 days

Due to Hypertension

Due to

Other Conditions Obesity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Preston Hunt M. D.
Address 1514 Division St Date signed 7/28/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53770

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G53770

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St
(c) Hospital or institution: Home for the Aged Room
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Mary Bidinger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	W.

6 (b) Name of husband or wife Wm. Bidinger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1868

8. AGE: Years	Months	Days	If less than one day
78	11	27	hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name No knowledge

13. Birthplace

14. Maiden Name No knowledge

15. Birthplace

16 (a) Informant Sister Superior The Poor
(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 28/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 E Biddle St

19 (a) JUL 26 1947 (Date rec'd by reg.) Huntington Will (Registrar) M. D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1947, at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947, to July 26 1947, and that I last saw him alive on 19.

Immediate cause of death	Duration
Intestinal obstruction	10 days.
Due to	
Due to Carcinoma of the Rectum	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jacob Fisher M. D.
Address 182 N. Paul St. Date signed 7/28/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C53771

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered C53771

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2503 Ellamont St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MRS IRIS FRANK (Iris E. Frank)

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lewis O. Frank
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1910

8. AGE: Years 37 | Months 0 | Days 11 | If less than one day hr. min.

9. Birthplace Somerset Co., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm. R. Lankford
13. Birthplace Somerset Co. Md.

MOTHER
14. Maiden Name Edith Dryden
15. Birthplace Somerset Co. Md.

16 (a) Informant Mr. Lewis O. Frank
(b) Address 2503 Ellamont St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/28/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Baltimore Co. Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address North & Pa. Aves.

19 (a) JUL 26 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1947 at 4:23 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 25 1947 to July 26 1947 and that I last saw h.m. alive on July 26 1947

Immediate cause of death Cerebral Hemorrhage — Duration
Due to Malignant Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Maurice A. Rosellini M.D.
Address Sinai Hosp. Date signed 7/26/47

G53772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G53772

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1618 Ellamont St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 Ellamont St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME STEPHEN MERRYMAN CARR

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	212-16-5930

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Rhoda M. Carr (nee Grady) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20, 1880

8. AGE: Years	Months	Days	If less than one day
67	4	5	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Benjamin Carr
13. Birthplace Md.

MOTHER
14. Maiden Name Eliz. A. Willis
15. Birthplace Maryland

16 (a) Informant Mrs. J. R. Price, stepdaughter
(b) Address 1618 Ellamont St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/28/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 JUL 26 1947 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25, 1947; at 3A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 27 1947, to July 25 1947, and that I last saw h[illegible] alive on July 24 1947.

	Duration
Immediate cause of death Carcinoma of Liver	1 yr.
Due to	
Due to	
Other Conditions Diabetes Mellitus (Include pregnancy within 3 months of death)	1 yr.
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Jon Cavernett M. D.
Address 1136 Poplar Grove St Date signed 7/26/47 M. D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ARROW RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G53773
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3507 Bank St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs 05

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Rural near Freeland. (If outside city or town limits, write RURAL and give town)
(d) Street No. Stiltz. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie May Diven

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife Charles M Diven

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) August 19, 1884.

8. AGE: Years 62 | Months 11 | Days 7 | If less than one day ____ hr. ____ min.

9. Birthplace Hoffmanville, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own home.

FATHER
12. Name Joseph Burke.
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret M. Hoffman.
15. Birthplace Hoffmanville, Md.

16 (a) Informant Charles Diven
(b) Address Glen Rock, Pa. R.D.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 29 1947 (month) (day) (year)
(c) Cemetery or crematory Stiltz Cemetery
Location Glen Rock, York Co. Penna.

18 (a) Funeral director Jacob Hartenstein
(b) Address New Freedom, Pa.

19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

JUL 27 vs 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26, 1947 at 9:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1947 to July 26 1947 and that I last saw her alive on July 18 1947

Immediate cause of death metastases

Due to Carcinoma Breast

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Denis J. McGrath M. D.
Address 3503 Fairfax Date signed 7/28/47

X

G53774

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 98

G53774

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) one
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 129 S Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clinton Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/18/1902

8. AGE: Years	Months	Days	If less than one day
45	4	6	hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Labora

11. Industry or business

FATHER
12. Name William Jackson
13. Birthplace Va

MOTHER
14. Maiden Name Mary Thompson
15. Birthplace Va

16 (a) Informant Joseph Jackson
(b) Address 704 S Main St Cumberland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/26/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Daniels L Brown & Son
(b) Address 128 N Montgomery St

19 (a) JUL 27 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1947 at 2:00 PM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Gangrene of Abdominal Wall

Due to

Other Conditions Necrosis of prostate

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl C Ryan M.D. (Medical Examiner.)
Date signed 7-24-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53775 — BALTIMORE CITY HEALTH DEPARTMENT — G53775

CERTIFICATE OF DEATH 63B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Women's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5d
(e) Length of stay in Baltimore (yrs., mos., or days) 5d

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna (b) County York
(c) City or town York
(If outside city or town limits, write RURAL and give town)
(d) Street No. 119 So. Beaver St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Georgia Kaye Small

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 25, 1929

8. AGE: Years: 23 yr | Months: 3 | Days: 1 | If less than one day: hr. min.

9. Birthplace York, Penna (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER
12. Name Percy Weigle Small
13. Birthplace York, Penna

MOTHER
14. Maiden Name Pauline Lehman
15. Birthplace York, Penna

16 (a) Informant Hospital Records
(b) Address Women Hospital Balt., Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 29 1947 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill Cem
Location York, Pa

18 (a) Funeral director William Cook Dorsey
(b) Address 217 St Paul St Md

19 7-27-1947 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 July 1947, at 9:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 21 July 1947, to 26 July 1947, and that I last saw her alive on 26 July 1947

Immediate cause of death: Cardiac standstill — Duration

Due to: during or shortly after total thyroidectomy — 6 hrs

Due to: Cyclopropane anesthesia

Other Conditions: None

(Include pregnancy within 3 months of death)

Date of operation 26 July 47

Major findings of operation: Thyroid mass at left superior pole

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.

Address Women Hospital Date signed July 29, 47

Godlove

G53776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G53776
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 days
(e) Length of stay in Baltimore (yrs., mos., or days) unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 731 S. Belnord St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Harrison Jester

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?, ?, 1879

8. AGE: Years	Months	Days	If less than one day
68	?	?	hr. min.

9. Birthplace Griffin, Ga.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business --

FATHER
12. Name Lee L. Jester
13. Birthplace Ga.

MOTHER
14. Maiden Name Clara Williams
15. Birthplace Ga.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/27/47 (month) (day) (year)
(c) Cemetery or crematory Griffin
Location Griffin Ga

18 (a) Funeral director Wilkens Bros Inc
(b) Address 1214 Cont St

19 (c) (Date received by Registrar) Huntington Williams Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1947, at 6:50PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 26 1947, to July 25 1947, and that I last saw him alive on July 25 1947

Immediate cause of death Pulmonary Tuberculosis, far advanced — Duration ?mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles P. Spicknall
Address U.S. Marine Hosp. Date signed 7-26-47 M.D.

X

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46

G53777 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2047 EAGLE St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days) 39 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2047 EAGLE St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROSE ETTLIN

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex FEMALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife NATHAN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 55 | Months | Days | If less than one day hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name JOSEPH TAYLOR
13. Birthplace RUSSIA

MOTHER
14. Maiden Name FANNIE
15. Birthplace RUSSIA

16 (a) Informant HUSBAND
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7-27-47 (month) (day) (year)
(c) Cemetery or crematory MT CARMEL
Location GERMAN HILL RD

18 (a) Funeral director VOLK LEWIS INC
(b) Address 400 EUTAW PL

19 (a) JUL 27 1947 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-25-47 19 ; at 10 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/30 1947 to 7/25 1947 and that I last saw her alive on 7/24 1947

Immediate cause of death Carcinoma of stomach — Duration 6 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 5/15/47

Major findings of operation Metastasis infiltrating Ca. of stomach

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Morrison

Address 11 E. Chase St Date signed 7/28/47

Huntington Williams, MD

X

G53778

BALTIMORE CITY HEALTH DEPARTMENT ✓ G53778

CERTIFICATE OF DEATH 93D

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3704 Chatham Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3704 Chatham Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Cohen

3 (b) If veteran, name war ✓

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Jenne

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 64 | Months | Days | If less than one day hr. min.

9. Birthplace Lithuania (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Samuel
13. Birthplace Lithuania

MOTHER 14. Maiden Name Not Known
15. Birthplace Lithuania

16 (a) Informant Wife
(b) Address

17 (a) Burial, (b) Date thereof 7-27-47 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Woodlawn Mem
Location Balto Md

18 (a) Funeral director Jack Levin Inc
(b) Address 1739 E. Balto St.

19 (a) Date of [illegible] (b) Tom Williams, M.D. Registrar

JUL 27 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1947 at 7:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1936 to July 25 1947 and that I last saw h.m. alive on July 25 1947

Immediate cause of death: Acute Coronary Occlusion — Duration: 5 minutes

Due to: Arteriosclerotic Heart Disease — 10 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Israel Rosen M.D.
M. D.

Address 2413 E Monument St Date signed 7/25/47

X

G53779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

G53779
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Franklin Square Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1340 W North Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Lawrence Dewlow

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-26-1354

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Nettie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct, 22, 1886

8. AGE: Years 60 | Months 9 | Days 3 | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Shoe Repairer

11. Industry or business

FATHER
12. Name Harry Dewlow
13. Birthplace Russia

MOTHER
14. Maiden Name Lena Hertzberg
15. Birthplace Ruaaia

16 (a) Informant Nettie Dewlow
(b) Address 1340 W North Ave

17 (a) Burial (b) Date thereof July 28, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run Cem.
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) Date Rec'd by registrar JUL 27 1947 (b) Huntington Williams, M.D. Registrar

VS 6

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1947, at 11.15 P. M

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained by said Inquiry find that said deceased came to his death on the day stated above.
(Autopsy or Inquiry) (Autopsy or Inquiry)

Immediate cause of death: Coronary Disease — Duration: 1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. H. Kammer Jr. M.D.
Medical Examiner.
Date signed 26 July 1947

G53780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93A

G53780 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + Saratoga Sts.
(c) Hospital or institution:
Mercy Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 714 W. Mulberry St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Martha Planter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife James A Planter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1883

8. AGE: Years	Months	Days	If less than one day
64	0	10	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name (Unknown)
13. Birthplace

MOTHER
14. Maiden Name Emma Knox
15. Birthplace Baltimore

16 (a) Informant James A Planter
(b) Address 714 W. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-27-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location

18 (a) Funeral director Mrs. Kate R. Williams
(b) Address 322 N. Schroeder St.

19 (a) 7 27 1947 Received by registrar Washington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1947, at 4:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 22 1947, to July 24 1947, and that I last saw h[illegible] alive on July 24 1947.

Immediate cause of death Congestive heart failure — Duration

Due to

Due to

Other Conditions Extreme obesity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert J. Johnson M. D.
Address Mercy Hospital Date signed 7/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correspondence is especially important. Physicians: please write the causes of death clearly and legibly.

G53781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

G53781

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3033 O'Donnell St.
(c) Hospital or institution: ----------
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ----------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3033 O'Donnell St. (If rural give location)
(e) Citizen of foreign country? ----- (Yes or No) If yes, name country ----------

3 (a) FULL NAME George Riedel

3 (b) If veteran, name war ----------
3 (c) Social Security Account No. ----------

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of wife: Mary Lewis Riedel
6 (c) If alive, give age ---years

7. Birth date of deceased (mo., day, yr.) April 17, 1871

8. AGE: Years 76 | Months 3 | Days 7 | If less than one day ---hr. ---min.

9. Birthplace Philadelphia, Penn. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business ----------

FATHER
12. Name Frederick Riedel
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Mary Lewis Riedel
(b) Address 3033 O'Donnell St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/29/47 (month) (day) (year)
(c) Cemetery New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. H. Mennard Son
(b) Address 805 N. Calvert St.

19 (a) (Date rec'd by registrar) JUL 27 1947 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1947 at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from January 1947 to July 24 1947, and that I last saw h alive on July 24 1947

Immediate cause of death: Carcinoma of Rectum — Duration 1 yr

Due to: ----------

Due to: ----------

Other Conditions: Metastasis generalized

(Include pregnancy within 3 months of death)

Date of operation: ----------

Major findings of operation: ----------

of autopsy: ----------

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: ----------
(b) Date of occurrence: ---------- at ---------- M
(c) Where did injury occur? ---------- (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ---------- While at work? ---------- (Specify type of place)
(e) Means of injury: ----------

23. Signature L. Edwin Muller M.D.
Address 2W Read St Date signed July 26 1947

G53782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163 H

G53782
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 803 W. North Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 803 W North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Popa Popa

3 (b) If veteran, name war

3 (c) Social Security Account No. 153-16-5137

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Emilia Popa

6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) March 31-1917

8. AGE: Years 28 | Months 3 | Days 25 | If less than one day ____ hr. ____ min.

9. Birthplace Jersey City - New Jersey
(Town, county, and state)

10. Usual Occupation Plumber

11. Industry or business

FATHER
12. Name Michael Popa
13. Birthplace Italy

MOTHER
14. Maiden Name Maiorcity ?
15. Birthplace New York City

16 (a) Informant Wife - Emilia Popa
(b) Address 803 W North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/27/47 (month) (day) (year)
(c) Cemetery or crematory
Location Jersey City New Jersey

18 (a) Funeral director Frank Della Vecchia
(b) Address 52 N. Market St Huntington W. Va.

19 (a) 7-27-1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1947, at 6 00 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to Carbon Monoxide Poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury July 26 1947 - 6 00 P M.
(b) Where did injury occur? 803 W North Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Open burners on gas range

23. Signature William J. Kelfried M.D.
Medical Examiner.
Date signed July 26, 1947

VS 151 RICHARD V. ROUCH - JERSEY CITY - UNDERTAKER

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

142B

G53783 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1622 McCulloh Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ADELINE HANEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7, 1918

8. AGE: Years 29 | Months 6 | Days 16 | If less than one day hr. min.

9. Birthplace Anniston, S. C.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Monroe Day
13. Birthplace Anniston, S. C.

MOTHER
14. Maiden Name Amanda Thompson
15. Birthplace Anniston, S. C.

16 (a) Informant Mr. William Haney
(b) Address 1622 N. McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 27, 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Rev. C. H. Hallaran
(b) Address 1629 Druid Hill Ave.

19 (a) (Date received by local registrar) (b) Registrar Huntington Williams, M.D.

JUL 27 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23, 1947, at 10.30 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemorrhage

Due to Ruptured tubal pregnancy, left

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.

Date signed 7-24-47

151

G53784

BALTIMORE CITY HEALTH DEPARTMENT ✓ G53784
CERTIFICATE OF DEATH 1141
Registered No.

Every item of information should be carefully supplied. The cause of death clearly and legibly. Physicians: please write PLEASE WRITE PLAINLY, WITH UNFADING INK. Even correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 650 N. Mulberry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Evans

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 251-07-0408

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Separated

6 (b) Name of husband or wife: Janie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/24/1906

8. AGE: Years	Months	Days	If less than one day
41	2	29	hr. min.

9. Birthplace S.C. (Town, county, and state)
10. Usual Occupation Steel Worker
11. Industry or business

FATHER
12. Name Wm. Evans
13. Birthplace S.C.

MOTHER
14. Maiden Name Jessie
15. Birthplace S.C.

16 (a) Informant Prince A. Evans (Bro)
(b) Address Darlington, S.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/27/47 (month) (day) (year)
(c) Cemetery or crematory Western Star
Location Balto. County, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave

19 (a) JUL 27 1947 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-23-1947, at 7:50 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lung abscess.
(over)
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Frank Evans M.D. Medical Examiner.
Date signed 7-24-47

X

G53785

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G53785
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address. Pennsylvania Ave
(c) Hospital or institution: Aged Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Govanda Hon
(If outside city or town limits, write RURAL and give town)
(d) Street No. Belvedere Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHIAM MORTCHA CAPLAN

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
man	white	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1831

8. AGE: Years	Months	Days	If less than one day
116			hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (b) Date thereof 7-27-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bnai Israel
Location Southern Ave

18 (a) Funeral director Jack Levin Inc
(b) Address 2100 Eutaw Pl

19 (a) JUL 27 1947 (b)
(Date rec'd by registrar) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-27 1947 at 7½ M

21. I certify that death occurred on the date above stated; that I attended deceased from Octob 1941 to 7-27 1947 and that I last saw h living on 7-27 1947

Immediate cause of death	Duration
Chronic cardio vascular disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry J Boyd M. D.
Address Govanda Hon Date signed 7-27-47

G53786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

Registered No. G53786

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LAFAYETTE AND JOHN
(c) Hospital or institution: WOMEN'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) +15 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W LEXINGTON
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country —

3 (a) FULL NAME MARTHA M. COLLARS

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife CHARLES COLLERS

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) MAY 17, 1867

8. AGE: Years 80 | Months 2 | Days 9 | If less than one day ____hr. ____min.

9. Birthplace CAMBRIDGE MARYLAND
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business NONE

FATHER
12. Name ROBERT THUMER
13. Birthplace CAMBRIDGE, MD

MOTHER
14. Maiden Name NELLIE COREY
15. Birthplace FEDERALSBURG, MD

16 (a) Informant MRS T.W. GLOVER
(b) Address 405 HIGHLAND AVE WILMINGTON DEL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 29 1947 (month) (day) (year)
(c) Cemetery or crematory Christ-Church
Location Cambridge, Md

18 (a) Funeral director Wm. Cook Inc
(b) Address 1217 St Paul St

19 (a) JUL 28 1947 (Date received by Registrar) Tuttington Williams, M.D. (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 July 19 47 at 10:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 21 July 19 47 to 26 July 19 47 and that I last saw h ER alive on 26 July 19 47

	Duration
Immediate cause of death BRONCHOPNEUMONIA	2 Day
Due to PORTAL CIRRHOSIS	'
Due to	
Other Conditions RT HEMIPLEGIA	9 YRS
POST CEREBROVASCULAR ACCIDENT (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation	
of autopsy: PORTAL CIRRHOSIS OF LIVER	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David B Agee Jr M.D.
Address Women's Hosp Date signed 28 July 47

X

G53787

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

G53787 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 W. Cold Spring Lane
(c) Hospital or institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Prince George's
(c) City or town Upper Marlboro
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME STANLEY DEALE.

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-20-6125

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	WIDOWER

6 (b) Name of husband or wife Alice Oliver

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31-1896

8. AGE: Years	Months	Days	If less than one day
51	1	26	hr. min.

9. Birthplace Prince Geo. Co. Md.
(Town, county, and state)

10. Usual Occupation Disabled

11. Industry or business Old Folks Home

FATHER
12. Name Leonard Deale
13. Birthplace P. Geo. Co. Md.

MOTHER
14. Maiden Name Clara Jones
15. Birthplace P. Geo. Co. Md.

16 (a) Informant Mrs. Mary Hostel
(b) Address Pittsville Md.

17 (a) Burial (b) Date thereof 7-27-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Upper Marlboro, Md.

18 (a) Funeral director Pittsville Bros.
(b) Address Upper Marlboro, Md.

19 JUL 28 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/27 1947, at 2:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/24 1947, to 7/27 1947, and that I last saw h[illegible] alive on 7-27 1947.

Immediate cause of death	Duration
(a) ACUTE CORONARY OCCLUSION	2 hrs.
(b) PLEURAL EFFUSION	3 days
(c) ERYSIPELAS	1 day
(d)	5 yrs.

Other Conditions EPILEPSY

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman R. Klenman M.D.
Address 3803 Edmondson Ave Date signed 7/27/47

VS 150

G53788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G53788

CWK-77764

117A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Years
(e) Length of stay in Baltimore (yrs., mos., or days) 62 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5 E. Hamburg Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Forsyth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of Husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 10-1884

8. AGE: Years	Months	Days	If less than one day
62	9	15	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Forsyth
13. Birthplace Maryland

MOTHER
14. Maiden Name Catherine Fischer
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/29/47 (month) (day) (year)
(c) Cemetery or crematory London Park Mt
Location Baltimore Md

18 (a) Funeral director William Cook Jr
(b) Address 1214 Pont St

19 (a) Filed July 28 1947 (b) Huntington Williams, M.D.
(Local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1947, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 2 1942 to July 25 1947, and that I last saw h im alive on July 25 1947.

	Duration
Immediate cause of death Generalized Peritonitis	3 days
Due to Massive perforation of Gastric Ulcer	3 days
Due to	
Other Conditions Severe Generalized Arteria-sclerosis (Include pregnancy within three months of death.)	
Date of operation July 24 1947	
Major findings of operation Perforated gastric ulcer on lesser curvature	
of autopsy As above	

PHYSICIAN: Underline the cause to which you charge statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address City Hosp Date signed 7-26-47 M. D.

G53789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓93D

Registered No. G53789

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 21 East Hill Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Baltimore
(c) City or town 21 East Hill Street
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) FULL NAME ISSAC ACKERMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife Fannie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Mrs Fannie Jinkins
(b) Address 3915 Norfolk ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-28-47 (month) (day) (year)
(c) Cemetery or crematory Herring Run
Location Balt. Md.

18 (a) Funeral director Jack Levin Inc
(b) Address 2100 Eutaw Place.

19 (a) JUL 28 1947 (Date rec'd by registrar) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/27/47 19 at 2A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D. (Medical Examiner)
signed 7/27/47

C53790

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 186A

Registered No. C53790

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: South Baltimore General Hospital ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5 E. Hamburg Street.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME ALICE WEAVER

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widow

6 (b) Name of husband or wife Walter
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Oct. 28, (1888)

8. AGE: Years	Months	Days	If less than one day
(59) 58	8	27 (28)	..... hr. ..... min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation.....
11. Industry or business

FATHER
12. Name Wm A Bennett
13. Birthplace Va

MOTHER
14. Maiden Name Nina Merrow
15. Birthplace Va

16 (a) Informant Mrs Georgie Sayers
(b) Address 21 E. Cross St

17 (a) Burial (b) Date thereof 7/28/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd

18 (a) Funeral director John F Henry Inc
(b) Address 21 E Light St Huntingtown, Williamsport, Md.

19 (a) JUL 28 1947 Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25, 1947, at 9.59 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull & intra-cranial hemorrhage

Due to.....

Other Conditions Fatty degeneration of liver -
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 23-2
(a) Date of injury 7-25-47 at 9.30 a. M.
(b) Where did injury occur? 5 E. Hamburg St. Baltimore, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury. Fell down stairs-inside house
Signature..... M.D.
Medical Examiner.
Date signed 7-25-47

G53791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G53791
Registered No.

226-316 / 1390

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State D. C. (b) County
(c) City or town Washington, (If outside city or town limits, write RURAL and give town)
(d) Street No. 5400 7th St. N.W. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fern Sherman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-25-20

8. AGE: Years	Months	Days	If less than one day
26	8	2	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name Russell Sherman
13. Birthplace W. Va.

MOTHER
14. Maiden Name Rosa Wimmer
15. Birthplace Iowa

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (b) Date thereof July 29 '47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Ft. Lincoln
Location Wash. D.C.

18 (a) Funeral director Deal Funeral Home
(b) Address 4812 Ga. Ave. N.W.

19 (a) 7-28-1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27- 1947, at 2:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-24- 1947 to 7-27- 1947 and that I last saw her alive on 7-27- 1947.

Immediate cause of death	Duration
Hypoglycemic Shock	6 hrs
Due to Post-operative insulin reaction	
Due to Diffuse liver & kidney damage	
Other Conditions Diabetes, chronic glomerulonephritis	

(Include pregnancy within 3 months of death)

Date of operation 7/26/47

Major findings of operation: Chr. Cystic Mastitis

of autopsy liver damage, chr. glom. nephritis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James R. Cain M.D.
Address The Johns Hopkins Hosp. Date signed 7/27/47

C53792

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947 A

Registered No. C53792

Every item of information should be carefully supplied. Type or write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2013 E Lanvale
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town 2013 E Lanvale
(If outside city or town limits, write RURAL and give town)
(d) Street No. Balto Md
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary (Mamie E) Schultz

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widow

6 (b) Name of husband or wife Louis L Schultz
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Bohl
13. Birthplace Germany

MOTHER
14. Maiden Name Dora Knorr
15. Birthplace Germany

16 (a) Informant Louis L Schultz
(b) Address 2013 E Lanvale

17 (a) Burial (b) Date thereof July 29
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore City
Location

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2106 Orleans St

19 July 28 1947 (b) Huntington Willis
(Date received by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1947 at 6:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1947 to July 26 19 47 and that I last saw her alive on July 25 19 47

Immediate cause of death	Duration
Cardiac Dilatation	1 day
Due to Portal Thrombosis	3 years
Cholelithiasis	6 months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert Eisenberg M.D.
Address 2025 E North Ave Date signed 7/26/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

Registered No. G53793

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2822 ~~Lorch~~ Raven Road
(c) Hospital or institution: *********
(d) Length of stay in hospital or inst. (yrs., mos., or days) ****
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2822 Loch Raven Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary (Mamie) A Martin.

3 (b) If veteran, name war: ***
3 (c) Social Security Account No. ***

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: ****
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 24 1877

8. AGE: Years 69 | Months 10 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John Martin
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Belle Meenagh
15. Birthplace Ireland

16 (a) Informant John J Martin (Brother)
(b) Address 2822 Loch Raven Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/29/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location North Ave Baltimore Md

18 (a) Funeral director J. Melville Jenkins.
(b) Address 2713 Kirk Ave

19 JUL 28 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1947, at 930 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 25 1947 to July 25 1947, and that I last saw him alive on July 25 1947.

Immediate cause of death: Coronary Occlusion — Duration: 1 day
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury None

23. Signature H. L. Gordy M.D.
Address 5706 Harford Rd Date signed 7-28-47

G53794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83A

G53794 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1506 Aisquith Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1506 Aisquith Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Catherine Martin

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Arthur J.Martin
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Oct. 29, 1891

8. AGE: Years 55 | Months 8 | Days 26 | If less than one day ######## min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frank O.Moran
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Catherine Anna Geis
15. Birthplace Baltimore, Md.

16 (a) Informant Arthur J.Martin
(b) Address 1506 Aisquith Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/29/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto: Md.

18 (a) Funeral director George J.Ruth, Inc.
(b) Address 1735 Harford Avenue

19 Date received JUL 28 1947 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25th 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1947 to July 25 1947, and that I last saw h[illegible] alive on July 25 1947.

Immediate cause of death: Hemorrhage Aspirated — Duration: 4 Hrs.
Due to: Hypotension
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:
23. Signature: Hugh A. Ruth M.D.
Address 3737 E. Balto St. Date signed 7/30/47

VS 150

G53795

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

Registered No. G53795

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LAFAYETTE AND JOHN STS.
(c) Hospital or institution:
WOMEN'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 12 DAYS

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County HOWARD
(c) City or town ELLICOTT CITY
(If outside city or town limits, write RURAL and give town)
(d) Street No. DORSEY HALL
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME WOLLIE MAY BLUNT

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife ROYDEN A BLUNT
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) MAY 27, 1894

8. AGE: Years	Months	Days	If less than one day
53	2	0	____ hr. ____ min.

9. Birthplace WILSON LA.
(Town, county, and state)
10. Usual Occupation HW
11. Industry or business HOME

FATHER
12. Name William THOMPSON
13. Birthplace ? LA.

MOTHER
14. Maiden Name AMELIA RUSSELL
15. Birthplace LA.

16 (a) Informant ELIZABETH BLUNT
(b) Address ELLICOT CITY, MD

17 (a) Burial (b) Date thereof 7-29-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Johns
Location Ellicott City, Md

18 (a) Funeral director F. H. Higinbotham
(b) Address Ellicott City Md

19 JUL 28 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 July 1947, at 5:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 16 July 1947 to 27 July 1947, and that I last saw HER alive on 27 July 1947

Immediate cause of death	Duration
CARDIO RESPIRATORY FAILURE	
Due to BILIARY CIRRHOSIS	10 YRS
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Jas B Agnew Jr M.D.
Address Woman's Hosp Date signed 27 July 47

G53796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓50

G53796 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 723 W. 34th. St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Buckingham Arms. 3706 N. Chas (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Cochran Supplee Smith

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife Howard R. Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 18, 1875

8. AGE:	Years	Months	Days	If less than one day
	71	11	7	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Home duties
11. Industry or business

FATHER
12. Name J. Frank Supplee
13. Birthplace Balto.

MOTHER
14. Maiden Name Kate Cochran
15. Birthplace Balto.

16 (a) Informant Howard R. Smith
(b) Address 3706 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 28, 1947 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount Av. & Oliver St.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place

JUL 28 1947
(Date rec'd by registrar) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 19 47 at 8:10 A M

21. I certify that death occurred on the date above stated, that I attended deceased from May 19 47 to July 19 47, and that I last saw her alive on July 23 19 47

Immediate cause of death
Carcinoma

	Duration
Due to Metastatic cancer of breast	1 month
Due to	1 year
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 1yr ago
Major findings of operation: Cancer of breast
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Josephine E. Leslie
Address 1101 St. Paul St. Date signed July 28 1947

Leslie

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓123

Registered No. G53797

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Colgate St
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Conn. (b) County
(c) City or town Westport (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Edmund W Nash

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Anne Steale
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1896

8. AGE: Years	Months	Days	If less than one day
51	5	2	hr. min.

9. Birthplace New York, N. Y. (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Edmund S. Nash
13. Birthplace Hillsboro, N. C.

MOTHER
14. Maiden Name Mathilde Chinault
15. Birthplace Louisville, Ky.

16 (a) Informant Mrs. Edmund W. Nash, Sr.
(b) Address Westport, Conn.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/29/47 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by local registrar) JUL 28 1947 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1947, at 6:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1947, to July 27 1947 and that I last saw him alive on July 25 1947.

Immediate cause of death	Duration
Peritonitis	
Due to Perforation of stomach	
Due to Carcinoma of stomach	9 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation July 22 47
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edmund S Bald M.D.
Address Union Memorial Hospital Date signed July 27

G53798

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

G53798 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6317 Park Heights Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Emma Feller

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife –
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1888

8. AGE: Years	Months	Days	If less than one day
59	5	8	hr. min.

9. Birthplace Beine, Switzerland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Tottlied Feller
13. Birthplace Switzerland

MOTHER
14. Maiden Name Madeline De Busches
15. Birthplace Paris, France

16 (a) Informant Mrs. Charles H. Diehl
(b) Address 5106 Arabia Ave.

17 (a) Burial (b) Date thereof 7/28/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUL 28 1947 Huntington Williams, Registrar
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1947, at 11:23 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 26, 1947 to July 27 1947 and that I last saw h[illegible] alive on July 27, 1947.

Immediate cause of death	Duration
Cerebro-Vascular Hemorrhage, Left	
Due to Cerebral Arterio-Sclerosis	
Due to	
Other Conditions Cerebro Vascular & Cardio-Vascular Art. Scl.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy Cerebro-Vasc. Hemorrhage, & Cardio-Vasc Art. Scl.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Allan Y. Wolinsky M. D.
Address Sinai Hospital Date signed 7-27-47

X

G53799

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131B

Registered No. G53799

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1308 Pilot Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 3

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore - Md 25
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1308 Pilot Court - 25
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Tracey Stewart

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-10-9456

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband~~ or wife: Ruth Louise Stewart

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 8 - 1889

8. AGE: Years 58 | Months 11 | Days 17 | If less than one day ... hr. ... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Cemetery Worker

11. Industry or business

FATHER
12. Name Samuel E. Stewart
13. Birthplace Maryland

MOTHER
14. Maiden Name Alvilda Bowen
15. Birthplace Maryland

16 (a) Informant Mrs Ruth Louise Stewart
(b) Address 1308 Pilot Court - 25 -

17 (a) Burial (b) Date thereof July 29-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross, Brooklyn
Location Gov Ritchie Highway

18 (a) Funeral director Milton Schilling
(b) Address 3914 Hanover St - 25

19 JUL 28 1947 (b)
(Date filed by Registrar) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25th 1947, at 8.15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1947 to July 25 1947 and that I last saw him alive on July 25 1947.

Immediate cause of death	Duration
Due to Cerebral Thrombosis	
Due to Hypertension	
Other Conditions Chronic nephritis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel E. Stewart M. D.
Address 203 Belvedere Date signed 7/29/47

X

G53800

Dr. Thomas Brennan
5217 Harford Road

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 109

G53800
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5503 Fair Oaks Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5503 Fair Oaks Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT CARL FLEMING

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9, 1935

8. AGE: Years	Months	Days	If less than one day
12	2	16	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Student
11. Industry or business Child

FATHER
12. Name Winter Morris Fleming
13. Birthplace Frederick, Md.

MOTHER
14. Maiden Name Edna Linten
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. W. M. Fleming
(b) Address 5503 Fair Oaks Avenue

17 (a) Burial (b) Date thereof 7/28/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) JUL 28 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25th, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1945 to July 25 1947 and that I last saw h[illegible] alive on July 25 1947.

Immediate cause of death Peripheral Circulatory Collapse — Duration

Due to Pneumonia

Due to Acute flareup of Chronic Arthritis.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas Brennan M. D.
Address 5217 Harford Rd Date signed 7-26-47

G53801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83A

Registered No. G53801

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Lawtoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3808 Southern Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Valentine Joseph Diegelman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Ida E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 20-1884

8. AGE: Years	Months	Days	If less than one day
62	9	5	hr. min.

9. Birthplace Balto. Md. (town, county, and state)
10. Usual Occupation Night Watchman
11. Industry or business

FATHER
12. Name Henry Diegelman
13. Birthplace Md.

MOTHER
14. Maiden Name Susanna Enders
15. Birthplace Germany

16 (a) Informant Mrs. Ida Diegelman
(b) Address 3808 Southern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-29-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Md

18 (a) Funeral director Leonard J. Leck
(b) Address 5305 Harford Rd.

19 (a) JUL 28 1947 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 July 1947 at 4:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 18 July 1947 to 25 July 1947 and that I last saw him alive on 25 July 1947.

	Duration
Immediate cause of death Cerebral Hemorrhage	
Due to arteriosclerosis generalized	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: arteriosclerosis generalized

PHYSICIAN
Underline the cause to which death should be charged [illegible]

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard A. Casey M.D.
Address Mercy Hospital Date signed 7/29/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

G53802

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1936 E. 30th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa C. Seibyl

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife John Seibyl
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31-1879

8. AGE: Years	Months	Days	If less than one day
67	11	25	hr. min.

9. Birthplace Balto - Md
(Town, county and state)

10. Usual Occupation at Home

11. Industry or business

FATHER
12. Name ✓
13. Birthplace ✓

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant Mrs. John Seibyl
(b) Address 3614 Gibbons Ave.

17 (a) Burial (b) Date thereof 7-29-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto

18 (a) Funeral director Leonard J. Lusk
(b) Address 5305 Harford Road.

19 (a) JUL 28 1947 Registrar for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1947, at 8 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947, to July 25 1947, and that I last saw her alive on July 25 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Faulty Nutrition	
Due to	
Other Conditions Hydrops of Gall-Bladder	

(Include pregnancy within 3 months of death)

Date of operation July 23/47

Major findings of operation: Same as above.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sidney H. Packer M. D.
Address University Hosp. Date signed July 25/47

X

G53803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G53803 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave. & Madison Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2019 Ellamont St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward M. Schmidt

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-07-0950

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Cecelia M. Schmidt

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Jan-7-1885

8. AGE: Years 62 | Months 6 | Days 24 | If less than one day ..... hr. ..... min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation Pipe Fitter

11. Industry or business Bell Fish Bldg Co.

FATHER
12. Name Charles Schmidt
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Minnie Eckhardt
15. Birthplace Balto. Md.

16 (a) Informant Cecelia M. Schmidt
(b) Address Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-29-47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Taylor Ave

18 (a) Funeral director John F. Melly Jr.
(b) Address 2425 E. Lafayette Ave

19 (a) Filed JUL 28 1947 (b) Registrar Huntington Mathews, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 July 1947, at 12:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 25 July 1947 to 26 July 1947 and that I last saw h alive on 26 July 1947

	Duration
Immediate cause of death: Coronary occlusion	
Due to: Hypertensive cardio-vascular disease	
Due to:	
Other Conditions: Lung abscess	6 months

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Allan Spies
Address Md. Gen. Hosp. Date signed 26 July 1947 M.D.

G53804 BALTIMORE CITY HEALTH DEPARTMENT G53804
CERTIFICATE OF DEATH 162B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 527 West Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 527 West Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Sallie Ann Taylor

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife John Taylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20, 1880

8. AGE: Years 67 | Months 4 | Days 5 | If less than one day hr. min.

9. Birthplace Rocky Mt. N.C. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Richmond Battle
13. Birthplace Rocky Mt. N.C.

MOTHER
14. Maiden Name Sabina Battle
15. Birthplace Rocky Mt. N.C.

16 (a) Informant Sabina Avaett
(b) Address 1130 Russell Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 28, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem. Location Baltimore Md

18 (a) Funeral director Chas O Wilson
(b) Address 1000 Hartley Ave

19 July 28 1947 (Registrar) Washington Williams (Deputy registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25, 1947, at 5:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 30, 1946, to July 25, 1947, and that I last saw her alive on July 23, 1947.

Immediate cause of death	Duration
CARDIAC Failure	Week
Due to Senility	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard H. Hunt M. D.
Address 1631 W. Franklin St. Date signed 7-26-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 189

X

G53805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 46 G

G53805 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Redwood
(b) Street address Lombard & Green Sts.
(c) Hospital or institution: University Hospital ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2217 Cedley St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME BERNARD A Sims SR (BENJAMIN.)

3 (b) If veteran, name war NONE

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife MARY. E SIMS

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 13 1889

8. AGE: Years 57 | Months 9 | Days 13 | If less than one day ____ hr. ____ min.

9. Birthplace Dist. of Columbia
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business BALTO MD

FATHER
12. Name FREDERICK. SIMS
13. Birthplace ENGLAND.

MOTHER
14. Maiden Name MARCELLA. MARTIN
15. Birthplace MARYLAND

16 (a) Informant WILLIAM A SIMS
(b) Address 2217 CEDLEY ST

17 (a) BURIAL (b) Date thereof JULY-29-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location BALTO MD

18 (a) Funeral director Bernard C Harle
(b) Address 121 E West St

19 (a) JUL 28 1947 (b)
(Date rec'd by registrar) Registrar

VS 150

Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1947, at 3:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1947, to July 26 1947, and that I last saw him alive on July 26 1947.

Immediate cause of death: Liver failure

Due to: Carcinoma head of pancreas

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. C. Duvall Jr. M. D.
Address University Hosp. Date signed July 26 47

X

G53806

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

G53806
Registered No.

Every item of information should be carefully supplied. The ... write the causes of death clearly and legibly. ... PLEASE WRITE PLAINLY, WITH UNFADING INK. ... correct age is especially important. Physicians: please write ...

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2718 Dillon St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Kwiatkowske

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Magdalena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19 1877

8. AGE: Years	Months	Days	If less than one day
70	4	7	hr. min.

9. Birthplace Poland.
(Town, county, and state)

10. Usual Occupation pensioner
11. Industry or business

FATHER
12. Name unknown
13. Birthplace Polant

MOTHER
14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Mrs Magdalena
(b) Address 2718 Dillon

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 30 47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location German Hill Road

18 (a) Funeral director Marie E. Fialkowska
(b) Address 1002 S. Howard Ave

19 (a) 28 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1947, at 9:55 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Helfrich M.D. Medical Examiner
Date signed July 27, 1947

G53807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G53807

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 E. Federal Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 E. Federal Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Finnan (LOUISE FINNAN)

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Joseph T. Finnan
6 (c) If alive, give age X years

7. Birth date of deceased (mo., day, yr.) Apr. 17, 1870

8. AGE: Years	Months	Days	If less than one day
77	3	8	hr. min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frederick Feige
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Roden
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Elmer I. Finnan
(b) Address 1701 E. Federal Street

17 (a) Burial (b) Date thereof 7/29/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY
(b)
(Date rec'd by registrar) (Registrar)

JUL 28 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 July 1947, at 11:30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardio-vascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer Jr. M.D.
Medical Examiner.
Date signed 26 July 1947

VS 181

G53808

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1930

G53808
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline St.
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 82

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTO
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2626 Brannon Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Thomas Brannan (THOMAS RICHARD BRANNAN)

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife: Catherine Brannan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-29-1865

8. AGE: Years 82 | Months 3 | Days 27 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Real Estate

11. Industry or business retired

FATHER
12. Name ? Brannan
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr. Wm. S. Stockman
(b) Address 2626 Brannon Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/30/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) JUL 28 1947 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-27 1947 at 2 05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-22 1947 to 7-27 1947 and that I last saw him alive on 7-27 1947.

Immediate cause of death Peripheral vascular collapse.

Due to Arteriosclerotic C.V.D.

Due to

Other Conditions Hypostatic pneumonia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E May M. D.
Address St. Joseph's Hosp Date signed 7-27-47

X

G53809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131A

G53809 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 33rd + Calvert St.
(b) Street address ~~3702 Hayford Rd~~
(c) Hospital or institution: The Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days) 72 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3709 Belair Road (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Elizabeth Glaser (ELIZABETH GLASER)

3 (b) If veteran, name war — no
3 (c) Social Security Account No. — none

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
F	W	Married

6 (b) Name of husband or wife Edward Glaser
6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Aug. 18, 1874.

8. AGE: Years	Months	Days	If less than one day
72 yrs.	11	8	..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Peter Tiltman
13. Birthplace Germany

MOTHER
14. Maiden Name unknown
15. Birthplace Germany

16 (a) Informant Daughter Mrs. Eva Meyer
(b) Address 3621 Fenyon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/30/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director H. Sanders Sons Inc
(b) Address North + Broadway

19. (a) ..... (b) ..... (Date received by registrar)

JUL 28 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26, 1947, at 7.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 26 1947 to July 26 1947 and that I last saw h[illegible] alive on July 26 1947.

Immediate cause of death C-R-Failure — Duration —
Due to Arteriosclerotic Cardio Vascular Renal disease — Duration —
Due to — Duration —
Other Conditions Urinary retention — Duration —
(Include pregnancy within 3 months of death)
Date of operation 0
Major findings of operation: 0
of autopsy: 0

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John M. Slaughter M. D.
Address Union Memorial Hosp. Date signed 7/28/47

G53810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

G53810 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1510 Mc Elderry St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1510 Mc Elderry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Hudson White
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 66 | Months | Days | If less than one day hr. min.

9. Birthplace Allen, Md
(Town, county, or state)

10. Usual Occupation Domestic

11. Industry or business

MOTHER / FATHER

12. Name Henry Tull

13. Birthplace Allen, Md.

14. Maiden Name Julia Parsons

15. Birthplace Allen Md

16 (a) Informant Hudson White

(b) Address 1510 McElderry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 28-1947 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cemetery
Location A.A. Co. Md.

18 (a) Funeral director Robert E. Williams

(b) Address 1515 McElderry St

19 JUL 28 1947 (Date received by Registrar) (b) Funeral Director Williams Md (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1947, at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 2 1946 to July 26 1947, and that I last saw h.e alive on July 24 1947.

Immediate cause of death

(a) Mitral Insufficiency — Duration 1 y

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Edward Fisher M.D.
Address 2 E Lanvale St Date signed 7-28-47

G53811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83A

Registered No. G53811

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1915 Sapp St
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1915 Sapp St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert Brown

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct: 10-1892

8. AGE: Years 54-5-5 | Months 9 | Days 15 | If less than one day hr. min.

9. Birthplace Buckingham Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Charles Brown
13. Birthplace Va

MOTHER 14. Maiden Name Lucy Logan
15. Birthplace Va

16 (a) Informant Lillian Johnson
(b) Address 1654 Bolton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-29-47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto. Co.

18 (a) Funeral director Bayser Sanders
(b) Address 1417 E. Preston St

19 JUL 28 1947 (Date rec'd by registrar) (b) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1947 at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-21-47 19 to 7-25- 1947, and that I last saw h alive on 7-24- 1947

Immediate cause of death: Cerebral Hemorrhage — Duration: 4 da

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. L. Fahrney, M. D.
Address 238 N Carey St Date signed 7-27-47

X

G53812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

181

Registered No. G53812

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTO.
(c) City or town Sparrows Point (If outside city or town limits, write RURAL and give town)
(d) Street No. 1001 K Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jasper Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife Amanda Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-15-1892

8. AGE: Years	Months	Days	If less than one day
54	10	12	hr. min.

9. Birthplace Buckingham Co. Va. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Steel Mill

FATHER
12. Name Anthony L. Brown
13. Birthplace Virginia

MOTHER
14. Maiden Name Elsie Brown
15. Birthplace Virginia

16 (a) Informant Robbie White
(b) Address Washington D.C.

17 (a) Ship (b) Date thereof 7-30-47
(Burial, cremation or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Buckingham Co Va.

18 (a) Funeral director Reuben Sanders
(b) Address 1417 E. Preston St

19 (a) JUL 28 1947 (b) Huntington Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27, 1947, at 5:45 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Toxemia

Due to 2nd & 3rd degree burns.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-11-47 at 53-00 M.
(b) Where did injury occur? Bethlehem Steel
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? yes
(d) Means of injury Burned by caustic Solution

23. Signature Howard J. Peterson M.D.
Medical Examiner.
Date signed 7-28-47

VS 151

G53813 BC# 284566

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

Registered No. G53813

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. St. Joseph's Hosp. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 7727 Fairgreen Rd

3 (a) FULL NAME Twyla Collen Scharf

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/25/47

8. AGE: Years | Months | Days 2 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name George W. Scharf
13. Birthplace Baltimore

MOTHER
14. Maiden Name Lucille
15. Birthplace Bray

16 (a) Informant Lucille Scharf
(b) Address 7727 Fairgreen Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/28/47 (month) (day) (year)
(c) Cemetery or crematory Jacul Front
Location Jerman Hill Rd.

18 (a) Funeral director John J. Dwyer
(b) Address 2629 Hudson St.

19 (a) JUL 28 1947 (To be filled in by registrar) (b) Huntington Williams Mgr. Registrar's Signature

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/26/47 19..., at 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/25 1947 to 7/26 1947 and that I last saw her alive on 7/26 19 47.

Immediate cause of death	Duration
Respiratory Arrest	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work? (Specify type of place)
(e) Means of injury

23. Signature Anthony F. DiPaula M.D.
Address St. Joseph's Hosp. Date signed 7/27/47

VS 150

G53814 BCH G 84303

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161C

Registered No. G53814

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secour Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give county)
(d) Street No. 3509 Old Frederick Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Scheaffer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27 1947

8. AGE: Years | Months | Days | If less than one day hr. 10 min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles W Scheaffer
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Catherine E Stunt
15. Birthplace Baltimore Md

16 (a) Informant Charles W Scheaffer
(b) Address 3509 Old Frederick Road

17 (a) Burial (b) Date thereof July 29 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director Harry J Amigone
(b) Address 4204 Ridgewood Ave

19 (a) JUL 28 1947 (b) Huntington Williams M.D.
(Date received by local registrar) (Signature of local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27th 1947 at 7 45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 27 1947, to July 27 1947 and that I last saw him alive on July 27 1947.

Immediate cause of death: Erythroblastosis Chydrops fetalis

Due to Rh incompatibility.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy:

Duration
10 minutes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Walter B Sanger, M.D.
Address Bon Secours Hospital Date signed 7/28/47
M. D.

G53815

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83A

Registered No. G53815

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3602 Foster Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3602 Foster Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH TRAGER

3 (b) If veteran, name war	3 (c) Social Security Account No.
------	--------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Charles J. Trager
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Oct. 28, 1876

8. AGE: Years	Months	Days	If less than one day
70	8	29	hr. min.

9. Birthplace Baltimore County, Md.
(Town, county, and state)
10. Usual Occupation House-Work
11. Industry or business At Home.

FATHER
12. Name Charles Freund
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary Hermann
15. Birthplace Unknown

16 (a) Informant Charles J. Trager (Husband)
(b) Address 3602 Foster Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-31-47 (month) (day) (year)
(c) Cemetery or crematory 1st Un. Evangelical
Location O'Donnell St.

18 (a) Funeral director Charles S. Zeiler
(b) Address 3605 Fait Ave.

19 (a) July 28 1947 (Signature of local registrar) Huntington Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1947 at 2:20 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Sept. 1, 1946 to July 27 1947, and that I last saw h.e alive on July 27 1947.

Immediate cause of death Cerebral Hemmorrhage — Duration 18 hrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James H. Haskel M. D.
Address 607 S. Conkling St. Date signed 7/28/47

G53816

BALTIMORE CITY HEALTH DEPARTMENT 186 A ✓

CERTIFICATE OF DEATH

Registered No. G53816

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert St.
(c) Hospital or institution: Mercy Hospital 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2409 Rosalyn Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME KUNIGUNDA DIEM

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife None
6 (c) If alive, give age ~~years~~

7. Birth date of deceased (mo., day, yr.) Aug 1, 1854

8. AGE: Years	Months	Days	If less than one day
92	11	26	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Home Keeper
11. Industry or business

FATHER
12. Name John Diem
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Rabit
15. Birthplace Germany

16 (a) Informant Sister
(b) Address 2409 Rosalyn ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof (month) July 29-47 (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4300 Belair Rd.

18 (a) Funeral director MARTIN W. E. DIPPEL'S SONS
(b) Address LOMBARD & ANN STS.

19 (a) JUL 28 1947 Huntington Williams M.D. Registrar
(b) Registrar's signature

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1947, at 1140 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947 to July 26 1947; and that I last saw h[illegible] alive on July 26 47.

Immediate cause of death Coronary Occlusion — Duration

Due to Age

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation July 26, 1947
Major findings of operation: Evidence of coronary occlusion
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence July 7th at M
(c) Where did injury occur? 2409 (City or town) Rosalyn Ave (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Slipped & fell to floor

23. Signature Geo. M. Jones M. D.
Address Mercy Hospital Date signed July 26

Ed. Merrill MD X

G53817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G53817 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 8 days
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 609 W. Lanvale St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: Edward William Burman

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: 215-10-0403

4. Sex: M
5. Color or race: col
6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: Hester Burman
6 (c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): Dec. 8, 1914

8. AGE: Years: 32 | Months: 7 | Days: 17 | If less than one day: hr. min.

9. Birthplace: Balto, Md. (Town, county, and state)
10. Usual Occupation: Cook & Baker
11. Industry or business: Seafarer

FATHER
12. Name: Edward Burman
13. Birthplace: Ge.

MOTHER
14. Maiden Name: Mary Wilson
15. Birthplace: SC

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 7/29/47 (month) (day) (year)
(c) Cemetery or crematory: Mt Calvary
Location:

18 (a) Funeral director: CHARLES R. LAW
(b) Address: 502 MADISON AVE.

19 (a) JUL 28 1947 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 25 1947, at 2:05P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 17 1947, to July 25 1947, and that I last saw him alive on July 25 1947.

Immediate cause of death: Neoplasm of undetermined type, intestines, mesentery, liver, heart, urinary bladder, spleen, stomach, pancreas, esophagus, lymph nodes in general. — Duration: unknown

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Charles D. Kirchmaier
Address: U.S. Marine Hosp. Date signed: 7/25/47

VS 180

G53818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BC# B84955 159

Registered No. G53818

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits write RURAL and give town)
(d) Street No. 3333 N. Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VALIANT SWAN (Baby Girl)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1947

8. AGE: Years | Months | Days | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert G Swan
13. Birthplace Watertown N Y

MOTHER
14. Maiden Name Dorothy Ann Hodge
15. Birthplace Camden N J

16 (a) Informant Robert G Swan
(b) Address 3333 N. Charles

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof July 28 1947 (month) (day) (year)
(c) Cemetery or crematory Dorsey Mount
Location Baltimore Md

18 (a) Funeral director Wm Cook Inc
(b) Address 217 St Paul St Balto

19 (a) JUL 28 1947 (Date received by Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/27 1947, at 1:00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/26 1947 to 7/27 1947 and that I last saw her alive on 7/22 1947

Immediate cause of death: Massive atelectasis, bilateral — Duration: 25 hrs.

Due to

Due to

Other Conditions Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Atelectasis, massive, bilat.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Manley H. Steinberg

Address Sinai Hospital Date signed 7/28/47

X

G53819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 16

Registered No. G53819

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 609 Harwood Avenue
(c) Hospital or institution: --
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 609 Harwood Avenue
(If rural give location)
(e) Citizen of foreign country? -- (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Leroy Cornell

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Amy L. Cornell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20, 1897

8. AGE: Years	Months	Days	If less than one day
50	1	8	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Office Work
11. Industry or business Social Security Board

FATHER
12. Name Joseph E. Cornell
13. Birthplace Maryland

MOTHER
14. Maiden Name Katie E. Wilhelm
15. Birthplace Maryland

16 (a) Informant Mrs. Amy L. Cornell
(b) Address 609 Harwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 30 1947 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Pk.
Location Baltimore Co.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) JUL 28 1947 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1947, at 2:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-21-1947 to 7-28-1947 and that I last saw him alive on 7-28-1947

Immediate cause of death Tuberculosis. Abscess of cervical spine. — Duration 4 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert F. Grawitch M. D.
Address 614 N. Paca St. Date signed 7/28/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53820 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G53820

CERTIFICATE OF DEATH 94A

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3706 Falls Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lorenzo D. Penn

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-09-5981

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Pearl Penn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 1- 1880

8. AGE: Years 66 | Months 8 | Days 25 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Baltimore Corporation

FATHER
12. Name Milton H. Penn
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Catherine Grimes
15. Birthplace Maryland

16 (a) Informant Mrs Melva M. Deering
(b) Address Sparrows, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 29-1947 (day) (month) (year)

(c) Cemetery or crematory Pleasant Hill Cem. Location Carroll Co., Maryland

18 (a) Funeral director Burns Funeral Home
(b) Address 3631 Falls Road

19 (a) JUL 28 1947 (Date rec'd by registrar) Hunting Town Williams, M.D. (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1947 at 4:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wilbur L. Hellbach M.D. (Medical Examiner)
Date signed July 26, 1947

G53821

CMK-35803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

18 A

G53821 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the exact age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Years
(e) Length of stay in Baltimore (yrs., mos., or days) 71 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town [illegible]
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3710 Clipper Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Andrew Martin

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife: Mattie (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 30-1876

8. AGE: Years	Months	Days	If less than one day
71	3	16	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles W. Martin (D)
13. Birthplace ?

MOTHER
14. Maiden Name Mary Allen (D)
15. Birthplace Ohio

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School JUL 25 1947

18 (a) Funeral director Commissioner of Health
(b) Address
19 JUL 28 1947 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 1947 at 3.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 29 1938 to July 16 1947 and that I last saw h im alive on July 16 1947.

Immediate cause of death: Strangulation due to aspiration of vomitus. Bronchopneumonia — Duration: 2 minutes

Due to: 1. Fracture left femur 2. Arteriosclerotic heart disease with decompensation 3. Anemia and generalized edema — Duration: 5 days

Due to

Other Conditions due to malnutrition.
(Include pregnancy within 3 months of death)

Date of operation 7/2/47

Major findings of operation: Insertion of Steinmann pin.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident 26-12
(b) Date of occurrence 6/28/47 at 10 A. M
(c) Where did injury occur? Baltimore, Baltimore, Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? B.C.H. Infirmary While at work? no (Specify type of place)
(e) Means of injury stumbled & fell

23. Signature R. T. Gibbs
Address Balti. City Hospitals Date signed 7/23/47 M. D.

VS 150 To be approved By Medical Examiner for John R. Oliver by Thomas J. Williams, M.D.

Dr. Earl Koons
120 G53822 L

BALTIMORE CITY HEALTH DEPARTMENT ✓ G53822
Registered No.

CERTIFICATE OF DEATH 97

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 2075
(b) Street address 2639 Rock Rose Avenue
(c) Hospital or institution: Home 1358
(d) Length of stay in hospital or inst. (yrs., mos., or days) -
(e) Length of stay in Baltimore (yrs., mos., or days) -

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2639 Rock Rose Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie C. Dobbs

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Glenn H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 1, 1864

8. AGE: Years	Months	Days	If less than one day
82	9	27	hr. min.

9. Birthplace New Jersey (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Jaggard
13. Birthplace New Jersey

MOTHER
14. Maiden Name Martha Cattell
15. Birthplace New Jersey

16 (a) Informant Charles H. Brineshults
(b) Address 2944 Harford Road

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof July 29 (month) (day) (year)
(c) Cemetery or crematory Harleigh.
Location Camden, New Jersey

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) JUL 28 1947 (Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 19 47, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 1947 to July 28 1947, and that I last saw h[illegible] alive on July 28 1947

Immediate cause of death	Duration
Cardiac Arthria	6 hours.
Due to Auricular fibrillation	1 hr.
Due to Hypertension	5 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Earl Koons M. D.
Address 1202 St Paul St Date signed July 28 47

X

G53823 BALTIMORE CITY HEALTH DEPARTMENT G53823
Registered No.

CERTIFICATE OF DEATH

131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard + Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James A. Minor

3 (b) If veteran, name war: WW
3 (c) Social Security Account No. 217-05-1499

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bertha
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1 1906

8. AGE: Years 41 | Months 3 | Days 26 | If less than one day hr. min.

9. Birthplace Lucketts Va (town, county, and state)

10. Usual Occupation Construction Worker

11. Industry or business

FATHER
12. Name Robert E Minor
13. Birthplace Lucket Va

MOTHER
14. Maiden Name Hattie Loy
15. Birthplace Lucket Va

16 (a) Informant Bertha Minor
(b) Address Sheyney Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/30/47 (month) (day) (year)
(c) Cemetery or crematory Mouland Memorial Park
Location Baltimore Co Md

18 (a) Funeral director Fulton Corp
(b) Address 1317 St Paul St

19 (a) JUL 28 1947 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/27, 1947 at 3:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/26 1947 to 7/27 1947 and that I last saw him alive on 7/27 1947

	Duration
Immediate cause of death Cardio-respiratory failure following convulsion	
Due to Uremia	Unknown
Due to Hypertension	Unknown
Other Conditions	Unknown

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. A. Phillips M. D.
Address University Hospital Date signed 7/27/47

G53824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G53824 Registered No. 170 C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2929 N. Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Sheridan Mc Clees

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Agnes E

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 23 1878

8. AGE: Years	Months	Days	If less than one day, hr. min.
69	6	4	

9. Birthplace Columbia (Town, county, and state) S C

10. Usual Occupation Lawyer

11. Industry or business Self

FATHER 12. Name Charles N. McClees

13. Birthplace Columbia S C

MOTHER 14. Maiden Name Sarah D MacRae

15. Birthplace Plymouth N C

16 (a) Informant Albert L Bumgarner

(b) Address 3333 N Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/30/47 (month) (day) (year)

(c) Cemetery or crematory Western

Location Baltimore Md

18 (a) Funeral director Tillyer & Son

(b) Address 2317 N Charles St

19 (a) JUL 28 1941 (Date rec'd by registrar) (b) Huntington Hollins, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1947, at 1:45 P M

21. I certify that I took charge of the remains described above, held an Autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed head
Fractured cervical vertebrae
Multiple lacerations & bruises.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-27-47 at 12:50 P M.
(b) Where did injury occur? Bonaparte Ave Aqueduct
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? no
(d) Means of injury Auto & auto collision

23. Signature Howard J. Thelen M.D. Medical Examiner.
Date signed 7-28-47

VS 151

D B G53825

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131A

Registered No. G53825

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1426 E. Monument St
(c) Hospital or institution: 10-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1426 E. Monument St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Belle Mason

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 73 | Months | Days | If less than one day hr. min.

9. Birthplace Whiteplain Va
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

MOTHER / FATHER

12. Name W. B. Mason

13. Birthplace Whiteplain Va

14. Maiden Name Mildred Benson

15. Birthplace Whiteplain Va

16 (a) Informant Claude Mason

(b) Address 1426 E. Monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 29, 47 (month) (day) (year)

(c) Cemetery or crematory Bishop Cem.

Location Whiteplain Va

18 (a) Funeral director Elizy O. Wilson

(b) Address 1000 Baltimore ave

19 (a) (Date received by registrar) Huntington Williams M.D.

JUL 28 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1947 at 5 55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947 to July 27 1947 and that I last saw h[illegible] alive on July 27 1947.

Immediate cause of death Uremia — Duration 3 days

Due to Chronic cardio-vascular-renal disease — Duration 1 yr.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. LeRoy Berry M.D.

Address 1420 E. Chase Date signed 7-28-47

X

G53826

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

G53826
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 810 Rutland ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 810 Rutland Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank P Jones Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Mall	Colord	Married

6 (b) Name of husband or wife Edith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5 188

8. AGE: Years	Months	Days	If less than one day
66	4	25	hr. min.

9. Birthplace Dinwiddie Co. Va (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Robert Jones
13. Birthplace Va

MOTHER
14. Maiden Name Unknown
15. Birthplace Va

16 (a) Informant Edyth Jones
(b) Address 810 Rutland Ave

17 (a) Burial (Burial, cremation, removal) (b) Date thereof July 29/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location

18 (a) Funeral director Wm. H. H. Ellis & Son
(b) Address 1124 N. Carolina St.

19 (a) July 29 1947 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

57

20. DATE OF DEATH July 26 1947, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 13 1947 to July 26 1947, and that I last saw h alive on 19

Immediate cause of death	Duration
Cerebral Sclerosis	2
Due to Cerebral Hemorrhage	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J Edward Fisher
Address 2 E Dromonent Date signed July 28/47

G53827

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

168

Registered No. G53827

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 16-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1304 W. Lafayette Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA CARTER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1918

8. AGE: Years 29 | Months | Days | If less than one day hr. min.

9. Birthplace Virginia (Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name John Jackson

13. Birthplace Va

MOTHER 14. Maiden Name Mariah Jackson

15. Birthplace Va

16 (a) Informant James Burrell

(b) Address 643 W. Franklin

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 29 47 (month) (day) (year)

(c) Cemetery or crematory Baltimore, Md.

Location

18 (a) Funeral director Troy O. Wilson

(b) Address 1000 Druid Hill Ave

19 (a) July 29 1947 (Date received by Local Registrar) (b) Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26, 1947, at 11.30 a.m.

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Dilatation of Cervical Vertebrae & Injury to Cord.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 7-22-47 at 1304 W. Lafayette Ave. M.

(b) Where did injury occur? Balto. Md.

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No

(d) Means of injury Pushed down steps at home.

23. Signature [signature] M.D. Medical Examiner

Date signed 7-28-47

X

G53828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 E

G53828 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1906 Hommond
(c) Hospital or institution: 9-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1906 Hommond Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes A Nugent

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: James G.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 4, 1881

8. AGE: Years 65 | Months 7 | Days 23 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant William J Nugent
(b) Address 2624 Roth St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/30/47 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore Md

18 (a) Funeral director Wilson Col Dye
(b) Address 1219 E Fayette St

JUL 29 1947 (Date received by local registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 4 1947 to July 27 1947 and that I last saw h alive on July 27 1947

Immediate cause of death: Carcinoma of descending colon & metastasis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation July 25 1947

Major findings of operation: Carcinoma descending colon

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jack J. Senger M.D.
Address 50 E North Ave Date signed 7-29-47

VS 150

G53829

BALTIMORE CITY HEALTH DEPARTMENT 13a X G53829 Registered No.

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Lontenberger

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 72

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mr. Shaufbough
(b) Address 6000 Bellona Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/29/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Milligan & Co Inc
(b) Address 2114 Gorsuch Ave

19 July 29 1947 (Date received by local registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1947, at 4:15 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 26 1947 to July 26 1947 and that I last saw him alive on July 26 1947

Immediate cause of death: Chronic Myocarditis — Duration: 1 day

Due to: Malnutrition — 7

Due to:

Other Conditions: Cirrhosis Salcyna — cirrhosis

Chronic Nephritis

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN: Underline cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Patrick Gordon M.D.
Address 11 W. 25th St Date signed July 28 47

VS 150

93D

G53830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

G53830 Registered No.

CM. 112302

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE.
(c) Hospital or institution: 4-1
Balto. City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 612 E. Baltimore ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Charles (Peter) Rada

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23 (Dec) 1893

8. AGE: Years	Months	Days	If less than one day
(54) 54	2	5	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Frank (Luder) Rada
13. Birthplace Bohemia

MOTHER
14. Maiden Name Josephine Von Strack (Sophie Bottisch)
15. Birthplace Bohemia

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/30/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Williams Col Sys
(b) Address 1210 E Col Sys

Date rec'd by Registrar 7 29 1947 Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 - 19 47 @ 6.30A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 1947, to July 28 1947 and that I last saw him alive on July 28 1947

Immediate cause of death	Duration
Uremia	7
Due to	
Due to	
Other Conditions Chronic glomerulonephritis. Hypertension Cardiovascular Dis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. T. Bamford M. D.
Address Balt. City Hosp. Date signed 7-28-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83A

Registered No. G53831

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1008 E. Hoffman Street
(c) Hospital or institution: Home 9-0
(d) Length of stay in hospital or inst. (yrs., mos., or days) -
(e) Length of stay in Baltimore (yrs., mos., or days) -

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1008 E. Hoffman Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Sophie Plantholt

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 212-01-4965A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 9, 1877

8. AGE:	Years	Months	Days	If less than one day
	69	9	18	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Saleslady
11. Industry or business

FATHER
12. Name John F. Plantholt
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Theresa Albert
15. Birthplace Germany

16 (a) Informant Mrs. M. J. Schaefer
(b) Address 1008 E. Hoffman Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 31-47 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Holy Redeemer Cemetery

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) Date received July 29 1947 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1947, at 7:39 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 8 1944 to July 27 1947 and that I last saw h[illegible] alive on July 27 1947.

Immediate cause of death: Myocardial Insufficiency — Duration: 3 days.
Due to: Apoplexy (Hem[illegible]) — 3 yrs.
Due to:
Other Conditions: Arteriosclerosis — 3½ yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John F. Segerstrom
Address 1802 Eastern Ave. Date signed 7-28-47 M. D.

X

G53832

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

Registered No. G53832

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2213 Mura St
(c) Hospital or institution: 9-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2213 Mura St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary F. Bertrand

3 (b) If veteran, name war W | 3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) ~~Single~~, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife George S. Bertrand

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 27th 186[illegible]

8. AGE: Years 85 | Months 9 | Days 27 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Collins
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name
15. Birthplace " "

16 (a) Informant Mrs A. Ewing
(b) Address 2213 Mura St.

17 (a) Burial (b) Date thereof 7/30/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Balto.
Location " Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (Date received by local registrar) JUL 29 1947 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26th 1947, at 4 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 19[illegible] to 7/26 1947.
and that I last saw her alive on 7/26 1947.

Immediate cause of death	Duration
Failure of Heart Action	[illegible]
Due to Arteriosclerosis	
Due to Chronic Myocarditis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 3323 E. Balto Date signed 7/27/47

X

G53833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

G53833
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3327 Elmora Ave
(c) Hospital or institution: 8-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3327 Elmora Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Ackerman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife: Lillian Ackerman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 20th 1876

8. AGE: Years 70 | Months 11 | Days 6 | If less than one day: hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Police Officer

FATHER
12. Name Andrew Ackerman
13. Birthplace Germany

MOTHER
14. Maiden Name Adelaide Morgenroth
15. Birthplace Germany

16 (a) Informant Mrs Lillian Ackerman
(b) Address 3327 Elmora Ave

17 (a) Burial (b) Date thereof 7/29/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 JUL 29 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26th 1947, at 11:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 12 1946, to Dec 24 1946, and that I last saw him alive on Dec 24 1946.

Immediate cause of death	Duration
Cerebral hemorrage	
Due to Arteriosclerotic cardio vascular disease	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edmund S. Hayes M.D.
Address 715 N. Chas St. Balto Md Date signed 7/29/47

X

G53834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G53834 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 401 N Loudon Ave
(c) Hospital or institution: 20-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 401 N. Loudon Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl R. Dean

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20, 1890

8. AGE: Years	Months	Days	If less than one day
57	0	8	hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Retired Secretary
11. Industry or business Sherwood Bros.

FATHER
12. Name late Edw. M. Dean
13. Birthplace Md

MOTHER
14. Maiden Name Ella Ruth
15. Birthplace Delaware

16 (a) Informant Mrs. Ella Ruth Dean
(b) Address 401 N. Loudon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 30/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director Harry H. Kibble
(b) Address 401 N. Edmondson Ave

19 (a) JUL 29 1947 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1947, at 1 00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1937 to July 28 1947 and that I last saw h-er alive on July 26 1947.

Immediate cause of death	Duration
Secondary anemia	6 weeks
Due to Carcinoma of pelvic organs — operation 1937	
Due to	
Other Conditions Metastasis — glandular (Carcinoma) (Include pregnancy within 3 months of death)	
Date of operation 1937	
Major findings of operation Carcinoma of pelvic organs	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter Stabler M. D.
Address 2220 Garrison Date signed July 28/47

G53835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 947

G53835

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4018 Ridgecroft Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4018 Ridgecroft Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John F. Eunzeman

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 213-05-5657

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Dora E. Eunzeman
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) July 20. 1897

8. AGE: Years 50 | Months 0 | Days 7 | If less than one day: hr. min.

9. Birthplace: Baltimore Md
(Town, county, and state)

10. Usual Occupation: Sheet Metal Worker
11. Industry or business: Wm. F. Gelles & Co.

FATHER
12. Name: Wm. F. Eunzeman
13. Birthplace: Baltimore Md

MOTHER
14. Maiden Name: Catherine Neuschafer
15. Birthplace: Baltimore Md

16 (a) Informant: Dora E. Eunzeman
(b) Address: 4018 Ridgecroft Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 30 1947 (month) (day) (year)
(c) Cemetery or crematory: Oaklawn
Location: Eastern Ave

18 (a) Funeral director: Mr. Mrs. John W. Teufelson
(b) Address: 5311 Edmondson Ave.

(a) (b) Huntington Williams, M.D.
(Date received by registrar) (Registrar)

JUL 29 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1947, at 8:55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 15 July 1947 to 19 July 1947 and that I last saw h[illegible] alive on 19 July 1947.

Immediate cause of death: Coronary Occlusion — Duration: 8 Months

Due to: —

Due to: —

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:
23. Signature: Howard Goodman M.D.
Address 1513 N. Milton Ave Date signed July 29 1947

Howard Goodman X

G53836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G53836 Registered No.

Every item of information should be carefully supplied. Type or write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 8 S. Curley St.
(c) Hospital or institution: ✓ 1-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8. S. Curley St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME DOROTHEA E. LE BRUN

3 (b) If veteran, name war —

3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Married

6 (b) Name of husband or wife John C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/3/93

8. AGE: Years	Months	Days	If less than one day
53	10	24	hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business at home

FATHER
12. Name John Francis Wenker
13. Birthplace Balto

MOTHER
14. Maiden Name Frederika Eyer
15. Birthplace Balto

16 (a) Informant John C Le Brun
(b) Address 8. S. Curley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/30/47 (month) (day) (year)
(c) Cemetery or crematory Loud Heart
Location Leon Hill Rd.

18 (a) Funeral director Feely & Feely & Co
(b) Address 2031 W Fayette St

(a) JUL 29 1947 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 July 1947, at 10 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 24 July 1947 to 27 July 1947 and that I last saw her alive on 26 July 1947

Immediate cause of death Massive Hypothorax — Duration 2 yrs 4 mos

Due to Metastatic Carcinoma of Lungs

Due to Carcinoma of Right Breast

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J Smith M. D.

Address 1127 N. Paul St Date signed 27 July 47

X

G53837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1949

G53837
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 907 Whitelock St
(c) Hospital or institution: 13-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 907 Whitelock St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Beatrice Rebecca Edlavitch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Julius

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1883

8. AGE: Years 64 | Months | Days | If less than one day hr. min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual Occupation: House Wife

11. Industry or business

FATHER
12. Name: Nachman Stein
13. Birthplace: Russia

MOTHER
14. Maiden Name: Sarah ?
15. Birthplace: Russia

16 (a) Informant: Miss Kate Edlavitch
(b) Address: 907 White lock St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 29, 1947 (month) (day) (year)
(c) Cemetery or crematory: Mishkin Israel Cemetery
Location: Southern Ave

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

JUL 29 1947 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29, 1947, at 5 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 5 1933, to July 29 1947, and that I last saw h alive on July 29 1947

Immediate cause of death	Duration
Coronary Thrombosis	1 week
Due to Hypertension	1939
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel Whitehorne M. D.
Address 1720 Eutaw Pl. Date signed 7/29/47

G53838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 111B

Registered No. G53838

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 17-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 871 Harlem ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Gertrude Jones

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-03-9865

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Wm Jones

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1, 1908

8. AGE: Years	Months	Days	If less than one day: hr.	min.
39	10	25		

9. Birthplace Richmond Va (Town, county, and state)

10. Usual Occupation Laundress

11. Industry or business

FATHER
12. Name Henry Price
13. Birthplace Va

MOTHER
14. Maiden Name Lyda Scott
15. Birthplace Va

16 (a) Informant Wm Jones
(b) Address 871 Harlem Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-30-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md

18 (a) Funeral director Wm. Francis E. Henry
(b) Address 578 W. Biddle St.

JUL 29 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1947, at 4:44 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D. Medical Examiner

Date signed 7-26-47

G53839

BALTIMORE CITY HEALTH DEPARTMENT 183

CERTIFICATE OF DEATH

Registered No. G53839

Found: Patapsco River -- Hammonds Ferry at Deanwood

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet St
(c) Hospital or institution: 18-3

(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6000 Carnation St
(If rural, give definitive location) 6 S. Carlton Ave
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Harrison

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 22 - 1904

8. AGE: Years	Months	Days	If less than one day
42	9	3	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Butcher
11. Industry or business

FATHER
12. Name William Harrison
13. Birthplace Md

MOTHER
14. Maiden Name Eliza Gueller
15. Birthplace Md

16 (a) Informant Henretta Johnson
(b) Address 6 N. Stockton St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 7-29-47 (month) (day) (year)
(c) Cemetery or crematory Western Star
Location Balto Co Md

18 (a) Funeral director Mrs Frances A Hemby
(b) Address 578 N Fiddle St

19 (a) JUL 29 1947 (b) Huntington Williams, MD
(Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1947, at 9 a.m. p.m.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Found drowned

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 7-26-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53840

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G53840 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST
(c) Hospital or institution: ST JOSEPH'S HOSP 26-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 8 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balti more (If outside city or town limits, write RURAL and give town)
(d) Street No. 5813 Kildee Court (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MIKELL, JAMES

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 251-07-8581

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Hazel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/16/1917

8. AGE: Years 30 | Months 0 | Days 11 | If less than one day ... hr. ... min.

9. Birthplace Bishopville, S.C. (Town, county, and state)
10. Usual Occupation Shipyard Worker
11. Industry or business Shipbuilding

FATHER
12. Name Manson Mikell
13. Birthplace Bishopville, S.C.

MOTHER
14. Maiden Name Mary Binul
15. Birthplace Bishopville, S.C.

16 (a) Informant Hazell Mikell
(b) Address 5813 Kildee Ct

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/1/47 (month) (day) (year)
(c) Cemetery or crematory Cooper's
Location Bishopville, S.C.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave

(a) JUL 29 1947 (Date received by registrar) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1947 at 7:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1947 to July 27 1947 and that I last saw him alive on July 27 1947

Immediate cause of death	Duration
RESPIRATORY FAILURE	
Due to MILIARY TBC, LUNGS	
Due to	
Other Conditions OSTEOMYELITIS, Rt ULNA LEFT TIBIA	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: MILIARY TBC, LUNGS

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry P. Porter M. D.
Address St. Joseph's Hosp. Date signed 7/27/47

G53841

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G53841

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5001 Pembridge Ave
(c) Hospital or institution: 27-17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5001 Pembridge Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nathan Eisenberg

3 (b) If veteran, name war —

5 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Hilda

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 54 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Grocery Store

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-29-47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Mem Pk
Location Wyndon Mill Rd

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Pl

JUL 29 1947 (a) (Registrar) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-25-47 19 , at 8:50 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 25 1947 to 19 ; and that I last saw him alive on July 25 19 47

Immediate cause of death Coronary Occlusion — Duration 45 minutes

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Joseph R. Ungerleider, M.D.
Address 5145 Park Heights Ave (Date signed) July 29, 1947

per G. G. Merrill

G53842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 117B

G53842
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2807 Huntingdon Ave
(c) Hospital or institution: 12-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2807 Huntingdon Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David F. Harrington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Catherine O. Harrington

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 24 1893

8. AGE: Years	Months	Days	If less than one day
53	7	3	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Retired Machinist
11. Industry or business Navy Yard.

FATHER
12. Name David Harrington
13. Birthplace Va.

MOTHER
14. Maiden Name Mary McKevin
15. Birthplace Va

16 (a) Informant Catherine O. Harrington
(b) Address 2807 Huntingdon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 30/47 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampden

18 (a) Funeral director Ehrenfeld & Donovan
(b) Address 3615-17 Eastern Ave.

19 (a) JUL 29 1947 (Date rec'd) (b) Huntington Williams M.D. (Registrar)

VS 144

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27, 1947 at 4 55 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1947 to July 27, 1947. that I last saw him alive on July 26 1947.

Immediate cause of death	Duration
Congestive Heart failure	
Due to Arteriosclerotic C.V.D.	
Due to	
Other Conditions Duodenal Ulcer	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward L. Harrington M. D.
Address 4037 Falls Rd. Date signed 7/29/47

931

G53843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G53843 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2423 Maisel Court
(c) Hospital or institution: 25-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2423 Maisel Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME AUGUST W. LEHNERT

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mary E. Lehnert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1892

8. AGE: Years	Months	Days	If less than one day
55	5	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Locke Insulator Co.

FATHER
12. Name Henry Lehnert
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mary Boetker
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Mary E. Lehnert, wife
(b) Address 2423 Maisel Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/29/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md. Kuntzleman-Williams, Mgr.

19 (a) 7/29/47 (Date rec'd by registrar) (b)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25, 1947 at 11:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1947 to July 25 1947, and that I last saw h alive on July 25 1947

Immediate cause of death	Duration
Due to Uraemia	
Due to Chronic nephritis Diabetes	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Rubin M. D.
Address 203 Eutaw Pl. Date signed 7/28/47

X

C53844

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. C53844

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2704 Chelsea Terr.
(c) Hospital or institution: 15-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2704 Chelsea Terr.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DR. HOWARD THOMAS MARTIN

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widower

6 (b) Name of husband or wife Anna L. Martin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21, 1866

8. AGE: Years	Months	Days	If less than one day
81	1	7	hr. min.

9. Birthplace Lancaster Co., Pa.
(Town, county, and state)
10. Usual Occupation Dentist
11. Industry or business

FATHER
12. Name Alexander Martin
13. Birthplace ?

MOTHER
14. Maiden Name ? Morrison
15. Birthplace ?

16 (a) Informant Dr. Wm. F. Martin
(b) Address 2704 Chelsea Terr.

17 (a) Removal (b) Date thereof 7/30/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hopewell Cem.,
Location Stewartstown, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28, 1947, at 12 30A. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 13 1947 to July 28 1947 and that I last saw h[illegible] alive on July 26 1947.

Immediate cause of death	Duration
Coronary occlusion	20 min.
Due to advanced arteriosclerosis	?
Due to	
Other Conditions Myocarditis	about 5 mo.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 2220 Garrison Blvd. Date signed July 29/47

X

G53845

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 A

Registered No. G53845

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Sorrento Ave.
(c) Hospital or institution: Colonial Nursing Home 16-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2739 Winchester St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPHINE GAVIN

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Walter J. Gavin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5, 1888

8. AGE: Years	Months	Days	If less than one day
59	4	23	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Pivec
13. Birthplace Prague

MOTHER
14. Maiden Name Josephine Gott
15. Birthplace Prague

16 (a) Informant Mr. Walter J. Gavin
(b) Address 2739 Winchester St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/31/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 7/29/47 (Date rec'd by registrar) (b) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28, 1947, at 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 10 1947 to July 28 1947, and that I last saw h alive on July 25 1947.

Immediate cause of death: Cancer of Cervix
Duration: 4 yrs
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jean Aschman M. D.
Address 201 Taylor Ave Date signed 7/29/47 M. D.

G53846

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G53846
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 700 Fleet Street.
(b) Street address
(c) Hospital or institution: 11-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 134 W. Preston Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY THOMPSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1852

8. AGE: Years	Months	Days	If less than one day
95 94			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Hill
(b) Address 1704 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-29-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 (a) 7/29/47 (Date rec'd by registrar) (b) Huntington Williamson, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25, 1947 at 11. A M

21. I certify that I took charge of the remains described above, held an inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature M.D.
Medical Examiner

Date signed 7-25-47

G53847

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G53847

Registered No.

CM. 112050 /131A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE.
(c) Hospital or institution:
Baltimore City Hospitals 11-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 18 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 140 Preston ST. 2 - 1
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willie Gilyard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Married

6 (b) Name of husband or wife Ida Gilyard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) March -10-1898

8. AGE: Years	Months	Days	If less than one day
49	4	18	hr. min.

9. Birthplace S.C.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Shiloh Gilyard (D)
13. Birthplace S.C.

MOTHER
14. Maiden Name Clara ?
15. Birthplace S.C.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-30-47 (month) (day) (year)
(c) Cemetery or crematory Hampstead
Location South Carolina

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

JUL 29 1947 (Registrar's signature) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 - 1947, at 2.30a M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1947 to July 28 1947, and that I last saw h. alive on July 28 1947

Immediate cause of death Respiratory failure — Duration

Due to Uraemia

Due to Nephrosclerosis

Other Conditions Hypertension malignant
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Ans. Loud.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William H. Kuckenbaker M.D.
Address Balto. City Hosp. Date signed 7-29-47

G53848

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

G53848 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 519 S.Luzerne Ave.
(c) Hospital or institution: 1-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 519 S.Luzerne Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth C.Primrose

3 (b) If veteran, name war --
3 (c) Social Security Account No. - -

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Wm.M.S.Primrose
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec.6,1873
8. AGE: Years 73 | Months 7 | Days 20 | If less than one day hr. min.
9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Charles Seyter
13. Birthplace Germany

MOTHER
14. Maiden Name Christina Haetchell
15. Birthplace Balto. Md.

16 (a) Informant Mr.Frederick Souders
(b) Address 6228 Sansom St.Phila.Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 29/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Balto. Md.

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Orleans St.

19 (a) JUL 29 1947 (Date received by Registrar) (b) Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26/47 19 , at 1:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/30 1947 to 7/26/1947 and that I last saw he alive on 7/25, 1947

Immediate cause of death Hypostatic Pneumonia — Duration 4 ds
Due to Acute Dilatation
Due to Chronic Myocarditis, Arteriosclerosis
Other Conditions Generalized Arterio-sclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mitchell F. Hartman M. D.
Address 1816 S. East Ave Date signed 7/28/47

X

G53849

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52A

G53849 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2531 W. Lafayette Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1½ yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 402 Delaware Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH SHOCK

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Ira Shock (deceased)
6 (c) If alive, give age /// years

7. Birth date of deceased (mo., day, yr.) March 22, 1874

8. AGE: Years	Months	Days	If less than one day
73	4	5	..... hr. ..... min.

9. Birthplace Woodlawn, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Jacob Lingenfelter
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Phillips
15. Birthplace Maryland

16 (a) Informant Mrs. Gertrude Young
(b) Address 2531 W. Layfayette Ave., Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 30, 1947 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Balto. Co., Maryland

18 (a) Funeral director John Burns Sons
(b) Address Towson, Maryland

19 (a) [illegible] (Signature of registrar) (b) Huntington Williams, M.D. Registrar

7/29/47

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27, 1947, at 2 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1947 to July 27 1947, and that I last saw h[illegible] alive on July 25 1947.

Immediate cause of death Hypernephroma of right Kidney
a metastasis to both Lungs

Duration 4 yrs.

Due to

Due to

Other Conditions Arteriosclerosis
Carcinoma vaginae Present.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Albert Johnston M. D.
Address 2202 Edmondson Ave Date signed 7/28/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C53850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131A

Registered No. C53850

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 679 N. Mulberry St
(c) Hospital or institution: 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 679 N. Mulberry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HESTER E. JONES

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/25/1877

8. AGE: Years 70 | Months 6 | Days 7 | If less than one day: hr. min.

9. Birthplace Staunton Va.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Henry Williams
13. Birthplace Va

MOTHER
14. Maiden Name Elizabeth Hankins
15. Birthplace Va.

16 (a) Informant Sylvester R. Jones
(b) Address 1915 Riggs Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-28-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna. Ave.

19 (c) Filed JUL 29 1947 Hunter for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1947, at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 23 1947 to July 27 1947. and that I last saw [illegible] alive on July 23 1947.

Immediate cause of death	Duration
(a) Interstitial Nephritis	7
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Douglas Sheppard M. D.
Address 604 N. Dulany Ave Date signed 7/29/47

G53851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55 E

G53851 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon Secours Hosp
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTO
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 730 Warwick Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Natalie Salvadore

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Rumania
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name ?
13. Birthplace Rumania

MOTHER
14. Maiden Name ?
15. Birthplace Rumania

16 (a) Informant Joseph Salvadore
(b) Address 730 Warwick Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 1 - 47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd

18 (a) Funeral director Joseph Kasmakis
(b) Address 60 E Washington Bel

JUL 29 1947 (Date rec'd by Registrar) (Transcription) Williams

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1947, at 7 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 9 1947 to July 28 1947 and that I last saw h.e.r. alive on July 28 1947.

Immediate cause of death Hemorrhage

Due to Metastatic melanosarcoma left inguinal region

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James Altwardt M. D.
Address Bon Secours Hospital Date signed 7/28/47

G53852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1108

Registered No. G53852

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Refer to the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1203 Franklintown Rd.
(c) Hospital or institution: 16-8

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1203 Franklintown Rd.
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Reba S. Dunlap

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	Negro	Separated

6 (b) Name of husband or wife Perry Dunlap 40
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/23/06

8. AGE: Years	Months	Days	If less than one day
41	4	3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name George Simpson
13. Birthplace Howard Co., Md.

MOTHER
14. Maiden Name Emelia Jackson
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Virginia Dunlap
(b) Address 1203 Franklintown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/30/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md

18 (a) Funeral director Wm. S. Nelson
(b) Address 1303 Presstman St

19 (a) JUL 29 1947 (Date Rec'd by Registrar) Linthicum Heights Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 19 47, at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/28 19 47 to 7/26 19 47 and that I last saw her alive on 7/26/ 1947

Immediate cause of death Lobar Pneumonia — Duration

Due to

Due to

Other Conditions Hypertensive heart disease with decompensation

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas K. Burgess M.D.

Address 601 N. Calhoun St Date signed 7/28/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

053853 BCH 884568

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160A

Register No. 053853

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline St. 8-5
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 3

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. St. Joseph's Hosp. (If rural, give location)
1912 E. Lafayette Ave
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Jean Margaret Berger

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 7/25/47

8. AGE: Years — | Months — | Days 2 | If less than one day — hr. — min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business —

FATHER
12. Name Kenneth W. Berger
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Frances A. Pacifico
15. Birthplace Baltimore, Md.

16 (a) Informant Frances A. Berger.
(b) Address 1912 E. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/29/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director C. J. Fanning & Son
(b) Address 1638 E. Lafayette Ave.

19 JUL 29 1947 (Date rec'd by registrar) (Huntington Williams, M.D.) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/27/47 19 ... at 2:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/25 1947 to 7/27 1947 and that I last saw h[illegible] alive on 7/27 1947

Immediate cause of death Respiratory Arrest — Duration —
Due to Intracranial Hemorrhage —
Due to Birth Injury —
Other Conditions None

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Anthony F. DiPaula, M.D.
Address St. Joseph's Hospital X Date signed 7/31/47

CHMielewski

G53854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓123

Registered No. G53854

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 2-2

(a) Baltimore City, Maryland

(b) Street address 1400 N. CAROLINE ST.

(c) Hospital or institution: ST Joseph's HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21

(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 420 S. ANN ST. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME (WLADYSLAWA) or LAURA CHMielewski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	WIDOW

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/15/84

8. AGE: Years	Months	Days	If less than one day
63	0	13	hr. min.

9. Birthplace POLAND (Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Poland

MOTHER 14. Maiden Name Unknown

15. Birthplace Poland

16 (a) Informant Mrs. (Genevieve) Gosh Daughter

(b) Address 420 S. Ann Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-30-47 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary Cem.

Location Baltimore County

18 (a) Funeral director John J. Weber

(b) Address 401 S. Chester Street

19 (a) 29 1947 (Date received by Registrar) (b) Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/28 1947 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/7 1947 to 7/28 1947 and that I last saw h alive on 7/28 1947

Immediate cause of death CARDIO Respiratory FAILURE — Duration

Due to Sepsis

Due to PERITONEAL Abscesses

Other Conditions INTESTINAL FISTULA

(Include pregnancy within 3 months of death)

Date of operation 7/25/47 & 7/19/47

Major findings of operation: Chronic cystitis Peritoneal abscess Intestinal fistula

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Harry O. Porter

Address St. Joseph's Hosp. Date signed M. D. 7/28/47

VS 190

24A

G53855

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G53855

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 912 W. Lombard St.
(c) Hospital or institution: 18-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 912 W. Lombard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Leary

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife late John Leary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1st 1869

8. AGE: Years 78 | Months 2 | Days 27 | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation house work

11. Industry or business at home.

FATHER
12. Name John Boyle
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Leary
15. Birthplace Ireland

16 (a) Informant Mr William J Leary
(b) Address 912 W Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/31/47 (month) (day) (year)
(c) Cemetery or crematory Loudenbeding
Location 4300 Pkg Frdg Road

18 (a) Funeral director John Lennon & Son
(b) Address 1101-03 Holliday St

19 (a) Filed July 29 1947 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1947 at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1947 to July 28 1947; and that I last saw her alive on July 28 1947

Immediate cause of death: Acute heart failure — Duration 1 hr.
Due to: Arteriosclerosis — years
Due to: General Asthenia & Senile Anemia
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Tommarello M.D. M. D.
Address 910 W. Lombard St. Date signed July 29 47

V S 150

CERTIFICATE CORRECTED 3-08-49

G53856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

Registered No. G53856

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 21-2
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1243 Sargent St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Leo J. Gibson Jr.

3 (b) If veteran, name war: WORLD WAR II
3 (c) Social Security Account No. 212-26-2564

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single DIVORCED
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 14, 1925
8. AGE: Years 22 | Months 10 | Days 13 | If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Asst Welder
11. Industry or business General Motor Corp.
FATHER 12. Name Leo J. Gibson
13. Birthplace Baltimore, Md.
MOTHER 14. Maiden Name Beulah V. Galloway
15. Birthplace Baltimore, Md.
16 (a) Informant Mrs Leo J. Gibson
(b) Address 1243 Sargent St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/30/47 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Frederick Ave
18 (a) Funeral director John J. Cowan & Sons
(b) Address 901 W Lombard St
19 (a) JUL 29 1947 (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1947 at 3:35 P.M.

20. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull
Intracranial hemorrhage
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-25-47 at 9:05 P.M. 19-1
(b) Where did injury occur? Franklin & Fulton Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? no
(d) Means of injury Hit by M. Joseph Co. Coll.

23. Signature George A. Merrill M.D. Medical Examiner.
Date signed 7-28-47

VS 151

G53857.

BALTIMORE CITY HEALTH DEPARTMENT

AB-111135

CERTIFICATE OF DEATH 30 E

G53857
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 17-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 18yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 735 Bradley St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Mary Louise Little

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 25- 1902

8. AGE: Years 44 | Months 6 | Days 24 | If less than one day hr. min.

9. Birthplace N.C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Speller
13. Birthplace N.C.

MOTHER
14. Maiden Name Minnie Erkins
15. Birthplace N.C.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School JUL 29 1947

18 (a) Funeral director Commissioner of Health
(b) Address
JUL 29 1947 Hunter Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19- 19 47, at 1.20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-3 19 47, to 7-19 19 47 and that I last saw h. alive on 7-19 19 47.

Immediate cause of death	Duration
Congestive Heart Failure	9 mo.
Due to Syphilitic Heart Disease	
Due to —	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm R Scarborough M. D.
Address Balto. City Hosp. Date signed 7-28-47

VS 150

G53858 BC# G 86264

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30 F

G53858 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 601 N. Broadway
(c) Hospital or institution: Johns Hopkins Hospital 10-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 908 Gay Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BABY BOY LEE (272198)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19, 1947

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Jones
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Lee
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address Johns Hopkins Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JUL 29 1947

18 (a) Funeral director Commissioner of Health
(b) Address

JUL 29 1947 (Date rec'd by Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19. 1947 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 18 19 47 to July 19 19 47, and that I last saw him alive on July 18 19 47.

Immediate cause of death	Duration
Congenital Syphilis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B C Williams

Address Johns Hopkins Hospital

G53859

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 43B

G53859 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton + Wilkens Ave
(c) Hospital or institution: St. Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 82 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry W. Peacocke Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male

5. Color or race white

6 (a) Single, married, widowed, or divorced single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2 1928

8. AGE: Years 19 Months 3 Days 26 If less than one day hr. min.

9. Birthplace Brooklyn New York
(Town, county, and state)

10. Usual Occupation student

11. Industry or business

FATHER
12. Name Harry W. Peacocke
13. Birthplace Sydney Nova Scotia

MOTHER
14. Maiden Name Dolores Hartwick
15. Birthplace Buffalo New York

16 (a) Informant Harry W. Peacocke
(b) Address 802 Edmondson Ave

17 (a) Burial (b) Date thereof July 29 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lord Baltimore
Location Howard County

18 (a) Funeral director Edward S. MacNabb
(b) Address Catonsville 28 Md

(a) Rec'd July 29 1947 (b) Registered Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/28 1947 at 2:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/4 1947 to 7/28 1947 and that I last saw him alive on 7/28 1947

Immediate cause of death Cardiac failure - tuberculosis Duration

Due to Kidney & Meningitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. W. Mintzer MD

Address St Agnes Date signed 7/28/47

J. W. MINTZER X

G53860

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X 50

G53860
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Univ. Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Sparks
(If outside city or town limits, write RURAL and give town)
(d) Street No. Belfast Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Berthal Hamlin / Bertha S. Hamlin

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Paul E. Hamlin

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 31 1882

8. AGE: Years 64 | Months 8 | Days 27 | If less than one day ..... hr. ..... min.

9. Birthplace Phila. Penna.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name
13. Birthplace Unknown

MOTHER
14. Maiden Name
15. Birthplace Unknown

16 (a) Informant Lynwood Hamlin
(b) Address Sparks, Md

17 (a) (Burial, cremation, or removal) (b) Date thereof 7-30-47 (month) (day) (year)

(c) Cemetery or crematory Univ. Md Medical School
Location

18 (a) Funeral director Landon M. Brooks
(b) Address Sparks, Md.

19 (a) JUL 30 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/27 1947 at 1:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/20 1947 to 7/27 1947 and that I last saw her alive on 7/27 1947

Immediate cause of death Acute dilatation of stomach - postoperative.

Due to Carcinoma of pancreas; partial obstruction

Due to

Other Conditions Carcinoma of breast, Hypertension C.V.D.
(Include pregnancy within 3 months of death)

Date of operation 7/26/47

Major findings of operation: Carcinoma of pancreas; metastases to liver

of autopsy:

Duration
Unknown

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. L. Phillips M. D.
Address University Hosp. Date signed 7/27/47

G53861

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193D

Registered No. G53861

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly; correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hamphet Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7b
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4329 Sheldon Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth L. Schmidt

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife: William Schmidt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1887

8. AGE: Years	Months	Days	If less than one day
60	1	12	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name August Betkey
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta (Unknown)
15. Birthplace Germany

16 (a) Informant William Schmidt
(b) Address 4329 Sheldon Avenue

17 (a) burial (b) Date thereof 7/31/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Baltimore County, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) Jul 30 1947 Funeral Director for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28, 1947, at 8:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947 to 7/28 1947 and that I last saw h[illegible] alive on 7/28 1947

Immediate cause of death Hypertension
Cardio-Vascular
Disease

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 5103 Harford Ave Date signed 7/29/47

G53862

BALTIMORE CITY HEALTH DEPARTMENT

Blk 6 32044 CERTIFICATE OF DEATH ✓ $3a

Registered No. G53862

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital 4
(d) Length of stay in Hospital or inst. (yrs., mos., or days) 1½
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3 N. Pearl Street
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Malcolm L Moore

3 (b) If veteran, name war: W

3 (c) Social Security Account No. N N B

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 27. 1940

8. AGE: Years	Months	Days	If less than one day
1	23 11	2	..... hr. ..... min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Madison L Moore

FATHER 13. Birthplace Roanoke Va

MOTHER 14. Maiden Name Ida E Spagoll

MOTHER 15. Birthplace Roanoke Va

16 (a) Informant Robert J Spagoll

(b) Address 3 Cole St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/31/47 (month) (day) (year)

(c) Cemetery or crematory Greenmount

Location Baltimore Md

18 (a) Funeral director Fulton Corl Inc

(b) Address 1214 Eutaw St

19 (a) JUL 30 1947 (Undertaker's signature) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1947, at 1 35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral edema

.....

.....

Due to.....

.....

Other Conditions.....

.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed 7-29-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53863

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56E

G53863

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Eight St.
(c) Hospital or institution: South Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 840 Harford Court (If rural give location)
(e) Citizen of foreign country? Md (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Bianca

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 8, 1933

8. AGE: Years	Months	Days	If less than one day
14	5	20	hr. min.

9. Birthplace New York City (Town, county, and state)

10. Usual Occupation schoolgirl

11. Industry or business

FATHER
12. Name Joseph Bianca
13. Birthplace Europe

MOTHER
14. Maiden Name Jennie Bondra
15. Birthplace Europe Italy

16 (a) Informant Father Joseph Bianca
(b) Address 840 Harford Ct.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 31/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd. Baltimore Md.

18 (a) Funeral director Frank Waller Neal
(b) Address 52 N. Morley St.

JUL 30 1947 (Date received by Registrar) (By) Huntington for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1947, at 4:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 27 1947, to July 29 1947, and that I last saw h.e alive on July 28 1947.

Immediate cause of death	Duration
Acute cardiac failure	2 hrs
Due to Generalized angiomatosis	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy see above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harold Dillon M.D.
Address South Balto Gen Hosp Date signed July 29

G53864

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

G53864 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring ave
(c) Hospital or institution: Levendale
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3954 Penhurst Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lipa Freedman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Anda

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, province or state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Mrs Sydney Rothbard
(b) Address 3954 Penhurst Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-30-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd + Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Pl

19 (a) 7-30 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1947, at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-15 1947 to 7-29 1947, and that I last saw h. alive on 7-29 1947

Immediate cause of death: Carcinoma of bladder — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H Edmund Levin

Address Levindale Date signed 7/29/47

C53865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. C53865

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1853 West North Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1853 W. North Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES A. WALTERHOEFER

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widow

6 (b) Name of husband or wife: Carrie (deceased)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1882

8. AGE: Years	Months	Days	If less than one day
65	0	23	hr. min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual Occupation: Salesman
11. Industry or business: Good Humor Ice Cream

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden Name: "
15. Birthplace: "

16 (a) Informant: Frank J. Childs
(b) Address: 1714 Chilton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/31/47 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn
Location: Eastern Ave. Rd. Balto. Md.

18 (a) Funeral director: Charles E. Schimunek
(b) Address: 3601-03 E. Madison Street

19 (a) JUL 30 1947 (Date received by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 19 47 at 3:30 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from July 27 1947 to July 29 1947 and that I last saw him alive on July 28 1947

Immediate cause of death	Duration
(a) Coronary Occlusion Acute	
(b) Dilatation of Heart	✓
Due to (c) General Arterio Sclerosis and	✓
Due to (d) Malnutrition	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: ✓
of autopsy none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Allen L. Graham M.D.
Address 121 Dolphin Street Date signed 7/30/47

G53866

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

G53866 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Ave.
(c) Hospital or institution: Mrs Snyder's Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 82 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. (or 4700 Harford) (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mary Blaylock Fowler

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Leonard F. Fowler
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 12 1859

8. AGE: Years 88 | Months 2 | Days 16 | If less than one day: hr. min.

9. Birthplace Charleston S.C. (Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER
12. Name David E. Badger
13. Birthplace Charleston S.C.

MOTHER
14. Maiden Name Ann A. Lee
15. Birthplace Baltimore

16 (a) Informant Dr. A. P. Badger (Son)
(b) Address 1111 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 30 47 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore

18 (a) Funeral director Stewart Mortuary Co.
(b) Address 108 W North Ave.

(a) Filed JUL 30 1947 (Date rec'd by Registrar) (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28, 1947, at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15 1942 to July 28 1947, and that I last saw h.e.v alive on July 26 1947

Immediate cause of death: Chr. myocarditis. — Duration

Due to: Chr. Nephritis

Due to:

Other Conditions: Arthritis

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos E. Hammond M.D.
Address 820 Medical Arts Bldg Date signed 7/29/47

G53867

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 192A

Registered No. G53867

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rutland & Monument
(c) Hospital or institution: Sinai

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1422 N. Chester St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Cosden

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
NO	NONE	F	W	W

6 (b) Name of husband or wife WM. A. COSDEN
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 16, 1893

8. AGE: Years	Months	Days	If less than one day
54	1	13	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name James C. McCoy
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Rose Gebhart
15. Birthplace Balto., Md.

16 (a) Informant Wm. Cosden
(b) Address Rte. 13, Box 357, Essex

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 1 47 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem.
Location Taylor Ave.

18 (a) Funeral director C. F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) JUL 30 1947 (b) Huntington Williams, M.D.

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/29 1947, at 6'5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/19 1947 to 7/29 1947 and that I last saw her alive on 7/28 1947.

Immediate cause of death Cardiac failure & pulmonary infarction — Duration 10 days

Due to Aortic Stenosis — 2 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Pulmonary infarct

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. A. Cohnheim M. D.
Address Sinai Hosp. Date signed 7/29/47

G53868

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

G53868 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1117 N Bond St.
(c) Hospital or institution
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1117 N Bond St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W. Pinder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	colored	married

6 (b) Name of husband or wife Mattie A. Pinder
6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1879

8. AGE: Years	Months	Days	If less than one day
67 68	10	20	hr. min.

9. Birthplace Dorchester County, Md
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name William Pinder
13. Birthplace Dorchester Co. Md

MOTHER
14. Maiden Name Mildanna Chase
15. Birthplace Dorchester Co. Md

16 (a) Informant Mattie A. Pinder
(b) Address 1117 N. Bond St.

17 (a) Burial (b) Date thereof Jul-30-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore - Md.

18 (a) Funeral director Mae Ida Bailey
(b) Address 1421 E. Jefferson St

19 JUL 30 1947 Date received by Registrar Hunting ton Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 July 1947 at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947 to 27 July 1947 and that I last saw h. alive on 26 July 1947.

Immediate cause of death Hypertension Uraemia — Duration

Due to Chronic Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. W. Chesser M.D.

Address 2659 Druid Hill Ave Date signed 27 July 1947

G53869

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54A

G53869 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 N. Lafayette Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thelma Scott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-24-37

8. AGE: Years 10 | Months 6 | Days 2 | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Harry L. Scott
13. Birthplace Md.

MOTHER
14. Maiden Name Edith Smith
15. Birthplace Md

16 (a) Informant Mr. Harry L. Scott
(b) Address 1602 N. Lafayette Ave

17 (a) Burial (b) Date thereof July 30, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Balto. Co. Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave

19 (a) July 30 1947 Filed by William M. [illegible]
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1947, at 2 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 5, 1947 to July 26 1947, and that I last saw her alive on July 26 1947.

Immediate cause of death	Duration
CARDIO. RESPIRATORY FAILURE	
ASPIRATION OF VOMITUS	
Due to (b) BRAIN TUMOR (MEDULLOBLASTOMA) - OPERATED	
Due to (c) POST OPERATIVE POST RADIATION - RECURRENCE	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 7/24/46

Major findings of operation: Malignant tumor

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William A. Spencer M. D.
Address JOHNS HOPKINS HOSP Date signed 7-28-47

G53870

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 170 C

Registered No. G53870

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 5 Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2102- Druid Hill Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BERTHA TALBOT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Amos Hudson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 18, 1894

8. AGE: Years 53 | Months 1 | Days 8 | If less than one day ____hr. ____min.

9. Birthplace: Calvert Co. Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: James Edward Egans
13. Birthplace: Calvert Co. Md.

MOTHER
14. Maiden Name: Mary Locke
15. Birthplace: Calvert Co. Md.

16 (a) Informant: Mrs. Amos Hudson Talbott
(b) Address: 2102 Druid Hill Ave.

17 (a) Burial (b) Date thereof 7/30/1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory: Arbutus Mem. Park
Location: Balto. Co. Md.

18 (a) Funeral director: Mrs. Edw. H. Holland
(b) Address: 1631 Druid Hill Ave.

19 (a) JUL 30 1947 (b) Huntingtor Williams, M.D.
(Date received) (Signature of Registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26, 1947, at 9 a. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured pelvis
Abdominal hemorrhage
Due to

Other Conditions

(Include pregnancy within 3 months of death).

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 11-4

(a) Date of injury 7-25-47 at 10.15 P. M.
(b) Where did injury occur? Druid Hill Ave. & Lanvale Baltimore, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Pediastrian-struck by 2 autos.

23. Signature: George T. Merrill M.D.
Medical Examiner.
Date signed 7-26-47

G53871

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G53871 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1334 Myrtle Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1334 Myrtle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William J. Baker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife Addie M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9, 1865

8. AGE: Years 82 | Months 1 | Days 19 | If less than one day hr. min.

9. Birthplace Centerville, Md.
(Town, county, and state)

10. Usual Occupation Elevator Operator

11. Industry or business

FATHER
12. Name William H. Baker
13. Birthplace Centerville, Md

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Lillian B. Hare
(b) Address 1334 Myrtle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 30, 1941 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md

18 (a) Funeral director Wm. George H. Holland
(b) Address 1631 Druid Hill Ave

19 JUL 30 1941 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1941, at 2 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1930 to July 28 1941, and that I last saw h-- alive on July 27 1941.

	Duration
Immediate cause of death: Myocarditis	1940
Hypertension Uremia	1940
Due to: Sequelae	
Uremia July 20	1941
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

By: Signature A. J. Hecht M.D.
Address 3426 Bank St. Date signed July 29/41

G53872

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95C

Registered No. G53872

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 531 Mather St
(c) Hospital or institution: 14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 531 Mather St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Martin

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Fe	Col.	Widowed

6 (b) Name of husband or wife James Martin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-1-1897

8. AGE: Years	Months	Days	If less than one day
50	2	28	hr. min.

9. Birthplace Gloucester, Virginia
(Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Lillian Corbett
(b) Address 1128 Etting St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-31-1947 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cemetery
Location Westport Md

18 (a) Funeral director George T. P. Gibson
(b) Address 1235 Edmondson Ave

19 (a) Date received JUL 30 1947 (b) Registrar Lexington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1947, at 5-P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 16 1947 to July 28 1947, and that I last saw her alive on July 28 1947.

Immediate cause of death: Organic Heart disease — Duration: Lifelong

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leland Chenault M.D.
Address 1534 Druid Hill Ave Date signed July 29

G53873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194A

G53873 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2219 N. Calvert St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul Vincent Collins

3 (b) If veteran, name war: World War II

3 (c) Social Security Account No. 211-07-0604

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-2-1907

8. AGE: Years	Months	Days	If less than one day
40	5	27	hr. min.

9. Birthplace Mt. Kessport, Pa (town, county, and state)

10. Usual Occupation Draftsman

11. Industry or business

FATHER
12. Name John J. Collins
13. Birthplace Mt. Kessport, Pa.

MOTHER
14. Maiden Name Sarah Donahue
15. Birthplace Mt. Kessport, Pa

16 (a) Informant Robert Collins
(b) Address 2219 No. Calvert St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof July 30, 1947 (month) (day) (year)

(c) Cemetery or crematory
Location Mt. Kessport, Pa

18 (a) Funeral director Wm J Tickner & Sons
(b) Address North & Penna Ave

JUL 30 1947 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1947, at 2 30 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Kaye M.D. (Medical Examiner)
Date signed 7-31-47

G53874

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G53874 Registered No.

V13C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 618 S. Luzurne St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 618 S. Luzurne St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John E. Kreczmer

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-16-9805

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28-1882

8. AGE: Years 65 | Months 2 | Days 1 | If less than one day hr. min.

9. Birthplace Atlanta Ga.
(Town, county, and state)

10. Usual Occupation Cabinet Maker

11. Industry or business Park fixture works

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Elmer Kreczmer
(b) Address 1813 Thames St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 1-47 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Balto City

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern Ave

19 (a) [illegible] (b) [illegible]

JUL 31 1947

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-29 1947, at 7:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-25 1947 to 7-29 1947 and that I last saw h[illegible] alive on 7-28 1947

Immediate cause of death: Pulmonary Th — Duration 1 M

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature N. J. Daintor M. D.

Address 3218 Eastern Ave Date signed 7-29-47

G53875 BC#D-68934

GM. 112338

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G53875

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE.
(c) Hospital or institution: Balto. City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 523 N. Gilmore ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eugene Bismark Kenny

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan -19 - 1947

8. AGE: Years	Months	Days	If less than one day
	6	8	hr. min.

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Eugene Kenny
13. Birthplace MD.

MOTHER
14. Maiden Name Gloria Freeman
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern AVE.

17 (a) Burial (b) Date thereof 7-30-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.
19 (a) 30 1947 (b) Huntingtor Williams Md
(Signature and address of funeral director)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 - 1947, at 8.05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 19 47 to July 27 19 47, and that I last saw him alive on July 27 - 19 47.

Immediate cause of death Bilateral bronchopneumonia — Duration 7 days

Due to organism undetermined

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Bronchopneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Reynold H. Becker M.D.
Address Balto City Hosp Date signed 7-31-47

G53876

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

Registered No. G53876

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 Pierce Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 63yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 Pierce Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Susan Johnson.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	MARRIED

6 (b) Name of husband or wife Horace Johnson, 75yr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years	Months	Days	If less than one day
85			hr. min.

9. Birthplace Westmoreland County, Va
(Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Horace Johnson
(b) Address 1701 Pierce

17 (a) Burial (b) Date thereof 7-30-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St.

19. Filed July 30 1947 (b) Huntington Williams M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27, 1947, at 3:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 30 1947, to July 27, 1947, and that I last saw her alive on July 26, 1947

Immediate cause of death	Duration
Coronary Occlusion	Day
Due to Senility	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard H. Hunt M. D.
Address 1631 W. Franklin St. Date signed 7-28-47

X

G53877

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 182

G53877
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Turner Station (If outside city or town limits write RURAL and give town)
(d) Street No. 719 New Pittsburgh Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Bell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Hattie Bell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1947. 1904

8. AGE: Years 42 | Months 10 | Days 26 | If less than one day: hr. min.

9. Birthplace Elberton, Ga. (Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER
12. Name Thomas Bell
13. Birthplace Elberton Ga.

MOTHER
14. Maiden Name Irene Ruggle
15. Birthplace Elberton Ga.

16 (a) Informant Mrs. Hattie Bell
(b) Address 719 New Pittsburg Ave. Turner Station

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 1, 1947 (month) (day) (year)
(c) Cemetery or crematory Asbury Memorial
Location C

18 (a) Funeral director Mrs. Kate R. Williams
(b) Address 322 N. Schroeder St.

19 (a) Date received JUL 30 1947 (b) Registrar Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-28- 1947 at 10 50 A.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Suffocation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7/28/47 at Bet. 9 & 10 A.M. 24-1
(b) Where did injury occur? American Sugar Refining
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes.
(d) Means of injury Buried when Sugar Bin Gave Way on him.

23. Signature [signature] M.D. Medical Examiner.
Date signed 7-28-47

G53878 Appeal by Med. Examiner Office

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1864

Registered No. G53878

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Madison & Linden
(b) Street address ~~2422 W. Lafayette Ave~~
(c) Hospital or institution: Md. Gen. Hosp. 16
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2422 W. Lafayette Ave,
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Virginia Bird Lorentz

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: F

5. Color or race: Wh

6 (a) Single, ~~married, widowed, or divorced~~

6 (b) Name of husband or wife: –

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28, 1863

8. AGE: Years 84 | Months 2 | Days 0 | If less than one day ... hr. ... min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Retired Nurse

11. Industry or business

FATHER
12. Name Marcellus Lorentz
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary E. Austin
15. Birthplace Virginia

16 (a) Informant Mrs. J. H. Wilburn
(b) Address 2422 W. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/31/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

(a) JUL 30 1947 (Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 July 1947, at 5-05 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4 July 1947 to 28 July 1947, and that I last saw h[illegible] alive on 28 July 1947.

Immediate cause of death Hypostatic pneumonia — Duration

Due to Cardiac decompensation

Due to

Other Conditions Fract., left femur

(Include pregnancy within 3 months of death)

Date of operation 24 July 1947

Major findings of operation: S transverse fem. inserted

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, ~~suicide, or homicide~~ No -
(b) Date of occurrence 3 July 1947 at 7 A. M.
(c) Where did injury occur? Baltimore (City or town) Md. (County) (State)
(d) Did injury occur about home, ~~on farm, industrial place, in public place~~? Home (Specify type of place) While at work? no
full in figure
(e) Means of injury Ft. fall in [illegible]

23. Signature Wm. T. Mitchell M. D.
Address Md. Gen. Hosp. Date signed 28 July

Reginald K. Davis, M. D. per Howard J. Mullis, M. D. 1947

G53879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G53879 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Middle River (If outside city or town limits, write RURAL and give town)
(d) Street No. 67 Seversky Court. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edna Terry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Emmett L. Terry

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) March 4-1898

8. AGE: Years 49 | Months 4 | Days 25 | If less than one day ... hr. ... min.

9. Birthplace Harford Co. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry T. Campbell
13. Birthplace Cecil Co. Md.

MOTHER
14. Maiden Name Mary Eliz. Asher
15. Birthplace Harford Co. Md.

16 (a) Informant Mr. Emmett L. Terry
(b) Address 67 Seversky Ct. Balto 29. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 1-47 (month) (day) (year)
(c) Cemetery or crematory Mouland Park
Location Taylor Ave.

18 (a) Funeral director Thos. S. Connelly
(b) Address 418 Eastern Ave. East

19 (a) ... (Date rec'd by registrar) (b) ... Registrar

AUG 30 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/29 1947, at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/28 1947 to 7/29 1947, and that I last saw her alive on 7/29 1947.

Immediate cause of death	Duration
Myocardial Infarction	
Due to	
Due to	
Other Conditions Diabetes Mellitus Shock; Hypoglycemia	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. J. Phillips M. D.
Address University Hosp Date signed 7/29/47

94A

G53880
106489-CWK

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G53880
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Mos
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2628 Ridgely Street Z-30
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minerva Johnson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Earl Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 18-1917

8. AGE: Years	Months	Days	If less than one day
29	7	9	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Everett Smith
13. Birthplace Maryland

MOTHER
14. Maiden Name Carria Pratt
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 5th 1947 (month) (day) (year)
(c) Cemetery or crematory Brewers Hill
Location West Street Extended

18 (a) Funeral director Wm. Chas. E. Kighs
(b) Address 43-45 Northeast St.

19 (a) (Date rec'd by registrar) (Signature of Registrar)

JUL 30 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1947, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from November 1929 to 46 to July 27-1947 and that I last saw her alive on July 27 1947.

Immediate cause of death	Duration
massive hemoptysis	5 min
Due to bilateral caseopneumonic pulmonary tuberculosis	5 yr
Due to	
Other Conditions none	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: old leasy abscess - Jan 1946
of autopsy see above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Joseph J. Bowers Jr. M. D.
Address Balto City Hosp. Date signed 7-29-47

G53881

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 931

G53881

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 806 E. 41ST. STREET
(c) Hospital or institution:
91
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 806 E 41st St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARIAN HOLT JONES

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Samuel B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11-1868

8. AGE: Years 79 | Months 3 | Days 18 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name John T. Holt
13. Birthplace Md.

MOTHER
14. Maiden Name Marian Horney
15. Birthplace Md.

16 (a) Informant Emma V. Jenkins
(b) Address 3641 Greenmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 1-47 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Olivet Greenmount

18 (a) Funeral director John A. Medairy
(b) Address 4201 Greenmount Ave.
(c) [illegible] 30 1947 [illegible] Washington Boulevard

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/29 1947, at EARLY MORNING

21. I certify that death occurred on the date above stated; that I attended deceased from ABOUT 4/1 1947, to ABOUT 4/30 1947, and that I last saw h E K alive on ABOUT 4/30 1947.

Immediate cause of death CONGESTIVE HEART FAILURE — Duration 4 MOS.

Due to HYPERTENSIVE CARDIO-VASCULAR DISEASE

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles W. Stewart, Jr. M. D.
Address 801 N. Eutaw St. Date signed 7/29/47

G53882

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83A

G53882
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 106 So. Gilmor St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) — 19
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 106 S. Gilmor St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William L. Crew.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-10-2780

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Bertie N. Crew.

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Dec. 9 - 1888

8. AGE: Years 58 | Months 7 | Days 20 | If less than one day: hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Ret. Street Car operator

11. Industry or business Balt. Transit Co.

FATHER
12. Name William J. Crew.
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Ida F. Rhine
15. Birthplace Balto Md

16 (a) Informant Mrs Bertie N. Crew
(b) Address 106 S. Gilmor St

17 (a) Burial (b) Date thereof 8-2-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto. Md

18 (a) Funeral director Geo. F. Beyer Jr
(b) Address 1512 Hollins St.

19 (a) Washington Williams
(Date rec'd by reg.) (Registrar)

JUL 31 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-29- 1947, at 8 47 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/28 19 47, to 28 19 47, and that I last saw h/ alive on 29 19 47.

Immediate cause of death: Cerebral Hemorrhage
Uremia —
Due to Arteriosclerosis —
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Joseph Landry M.D.
Address 447 N. Gilmor St Date signed 7/30/47

G53883 BALTIMORE CITY HEALTH DEPARTMENT G53883
CERTIFICATE OF DEATH 93D Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1642 E. Fort Ave #30 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Neenan
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife James Neenan
6 (c) If alive, give age 80 years
7. Birth date of deceased (mo., day, yr.) 6/15/1867

8. AGE: Years	Months	Days	If less than one day
80	1	13	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Michael Slattery
13. Birthplace Ireland

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mary Harrington
(b) Address 1642 E. Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/31/47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location B. A. Co.

18 (a) Funeral director Charles F. Dill
(b) Address 1001 E. Fort Ave.

19 (a) (Date rec'd by registrar) (b) [illegible] Registrar

JUL 30 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/28 1947, at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/27/47 19 to 7/28 1947, and that I last saw h on alive on 7/27 19 47

Immediate cause of death	Duration
Cardiac respiratory failure	
Due to Coronary sclerosis cardiovascular disease	Unknown
Due to	
Other Conditions Senility	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. S. Phillips M. D.
Address University Hosp. Date signed 7/28/47

G53884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 B

G53884
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5513 Norwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5513 Norwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM C. JONES

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Marie Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1885

8. AGE: Years	Months	Days	If less than one day
61	11	4	hr. min.

9. Birthplace Rock Hall, Md.
(Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business Industrial Power & Equipment Co.

FATHER
12. Name James A. Jones
13. Birthplace Cecil Co., Md.

MOTHER
14. Maiden Name Emma Bruff
15. Birthplace Kent Co., Md.

16 (a) Informant Mrs. Marie Jones
(b) Address 5513 Norwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/1/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

(c) Date rec'd by reg. 1947 (d) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30, 1947 at 1:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1946 to July 30 1947.
and that I last saw him alive on July 28 1947.

Immediate cause of death	Duration
Carcinoma of bladder	3 yrs
Due to	
Due to	
Other Conditions Metastatic Carcinoma of Colon	6 months

(Include pregnancy within 3 months of death)
Date of operation March 1947
Major findings of operation: Carcinoma of bladder
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Daniel J. Winston M. D.
Address 435 Juniper Rd. Balto Md. Date signed 7/30/47

G53885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 7138

G53885

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 808 E. Lexington St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1897

8. AGE: Years	Months	Days	If less than one day
50	1	18	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Henry Taylor
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Jennings
15. Birthplace Virginia

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Locality

18 (a) Funeral director
(b) Address

JUL 30 1947
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1947 at 9:51 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 9 1947 to July 23 1947, and that I last saw h[illegible] alive on July 23 1947.

Immediate cause of death Tuberculosis — Duration

Due to Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. B. Scott M.D.
Address Mercy Hospital Date signed 7/25/47

JUL 30 1947
Commissioner of Health
Hamilton for Williams M.D.

X

G53886

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

G53886 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: SINAI HOSP 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4301 Anntana Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MILDRED LUBER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Clarence G. Luber
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4th. 1907

8. AGE: Years	Months	Days	If less than one day
39	9	25	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Wm. Ashauer
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Amelia Rogers
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Clarence G. Luber
(b) Address 4301 Anntana Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 8/1/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location 3310 Taylor Ave.

18 (a) Funeral director Lazarus Funeral Home
(b) Address 7401 Belair Road

19 (a) Date 7-30-1947 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1947, at 7:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/18 1947 to 7/29 1947 and that I last saw h[illegible] alive on 7/29 1947.

Immediate cause of death	Duration
Renal Insufficiency	
Due to Chr. Pyelonephritis	
Due to	
Other Conditions ARTERIO SCLEROTIC AND HYPERTENSIVE Heart Disease (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: AS ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice A. Perelis M. D.
Address Sinai Hosp Date signed 7/29/47

G53887

pCH 84292

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1579

G53887

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lombard & Greene sts

(c) Hospital or institution: University Hospital W

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days

(e) Length of stay in Baltimore (yrs., mos., or days) 5 Days.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 511 Essex St.
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/17/47

8. AGE: Years | Months | Days 5 | If less than one day hr. min.

9. Birthplace University Hospital
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name William Johnson

13. Birthplace Wilmington, N.C.

MOTHER 14. Maiden Name Bertina Johnson

15. Birthplace Baltimore, Md.

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School JUL 30 1947

18 (a) Funeral director Commissioner of Health

(b) Address

(a) Registrar Huntington Williams, M.D.

JUL 30 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1947, at 7:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-17 1947 to 7-22 1947, and that I last saw h[illegible] alive on 7-22 1947

Immediate cause of death Asphyxiation

Foetus

Due to atelectasis

Due to Pre-Maturity

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature C. W. Whitmore M. D.

Address University Hospital Date signed 7/29/47

G53888

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131A

G53888 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: 2601 Frances Street 13
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2601 Francis St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME MARY MILLS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Joseph H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 16, 1864

8. AGE: Years 82 | Months 7 | Days 13 | If less than one day ....hr. ....min.

9. Birthplace Ellicott City, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Abraham Sager
13. Birthplace Maryland

MOTHER
14. Maiden Name Louisa E. Kestarson
15. Birthplace Maryland

16 (a) Informant Annie Jones
(b) Address 354 Towson Avenue, Essex

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 7/31/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
Address 1217 St. Paul Street
19 (a) 30 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1947, at 9 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardio-vascular-renal disease

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature George E. Merrill M.D.
Medical Examiner.
Date signed 7/29/47

White Paper, with ruling for ... Physicians: please write ... age is especially important.

G53889 B# B-67682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G53889 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1229 Scott St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Loretta Roberts

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 7, 1947

8. AGE: Years	Months	Days	If less than one day
	6	23	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name James Roberts
13. Birthplace Jackson Co Ga

MOTHER
14. Maiden Name Lana Ingram
15. Birthplace Hannock Co Ga

16 (a) Informant Emma Roberts
(b) Address 1229 Scott St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/31/47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Md
Location Arbutus Md

18 (a) Funeral director Wallace Funeral Home
(b) Address Baltimore Md

19 (a) (Filled in by registrar) (b) Registrar

JUL 30 1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-30 1947, at 6:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-24 1947, to 7-30 1947, and that I last saw her alive on 7-30 1947.

Immediate cause of death	Duration
Anoxia	
Due to Lobar Pneumonia, left lower lobe etiology undetermined	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Conrad M. D.
Address University Hospital Date signed 7-30-47

G53890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G53890 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 W LEXINGTON St
(c) Hospital or institution: Aged Women's & Girls' Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Emma Sullivan

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: NONE

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 22 1868

8. AGE: Years 78 | Months 7 | Days 8 | If less than one day hr. min.

9. Birthplace Relay MD (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name William L Sullivan
13. Birthplace Washington

MOTHER 14. Maiden Name Hannah E Riley
15. Birthplace Unknown

16 (a) Informant Aged Farmers & Ladies Home
(b) Address 1600 W Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/1/47 (month) (day) (year)

(c) Cemetery or crematory Dammann's
Location Baltimore MD

18 (a) Funeral director William Cook Jr
(b) Address 1217 E Fort Ave

19 (a) (Date rec'd by registrar) (b) Registrar

JUL 30 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1947, at 3:9 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 28 1947, to July 30 1947, and that I last saw her alive on July 26 1947.

Immediate cause of death	Duration
Cardiac Decompensation, Failure	
Due to Auricular Fibrillation	
with Hypostatic Pneumonia	
Due to Arteriosclerotic Heart disease	
Other Conditions Carcinoma Pancreas?	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Newland Edward Day M. D.
Address 4-E-33-4 St Balto 18 Date signed 7-31-47

93D

G53891 BALTIMORE CITY HEALTH DEPARTMENT G53891
CERTIFICATE OF DEATH 93D Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Caroline St.
(c) Hospital or institution: St. Josephs 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 44

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 906 S. Hanover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Lentini

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife Nerina

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-5-1869

8. AGE: Years 78 | Months 0 | Days 23 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Vincenzo Lentini
13. Birthplace Italy

MOTHER 14. Maiden Name Carmela
15. Birthplace Italy

16 (a) Informant Nerina Lentini
(b) Address 906 S. Hanover St.

17 (a) Will Burial (Burial, cremation, or removal) (b) Date thereof July 31 47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd. Balt. Md.

18 (a) Funeral director Frank Della Vecchia
(b) Address 52 N. Morley St.

19 (a) (Date received by Registrar) (b) for Williams, M.D. Registrar

JUL 30 1947

V9 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-30 1947 at 10 34 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-28 1947 to 7-30 1947 and that I last saw h[illegible] alive on 7-30 1947

Immediate cause of death Peripheral vascular collapse — Duration
Due to Arteriosclerotic C. V. Disease
Due to
Other Conditions Hypostatic pneumonia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E May M. D.
Address St Josephs Hosp Date signed 7-30-47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C53892 / 178a — Registered No. C53892

C53892

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 3-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1407 Gough Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: ARTHUR P. YACOLA

3 (b) If veteran, name war: II World War
3 (c) Social Security Account No. 212-20-6396

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: late Theresa M. Yacola
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10 1925

8. AGE: 22 Years | Months 0 | Days 19 | If less than one day hr. min.

9. Birthplace: Clearfield, Pa
(Town, county, and state)

10. Usual Occupation: ?

11. Industry or business

FATHER
12. Name: Joseph Yacola
13. Birthplace: Italy

MOTHER
14. Maiden Name: Pasqualina Imbriaco
15. Birthplace: Italy

16 (a) Informant: Pasqualina Yacola Mather
(b) Address: 312 S. Eden St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 2nd 47 (month) (day) (year)
(c) Cemetery or crematory: Baltimore National
Location: 5501 Frederick Ave.

18 (a) Funeral director: Powell Dallas Mease
(b) Address: 52 N. Morley St. Huntingtown Williams, Md.

30 1947 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION — a

20. DATE OF DEATH: July 29, 1947, at 11.25 M

21. I certify that I took charge of the remains described above, held an exam. & insp. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑ prob., suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Asphyxiation

Due to Illuminating Gas.

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-29-47 at 11 a. M. 3/1
(b) Where did injury occur? 1407 Gough St. Baltimore, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury: Gas burners stove on unlit

23. Signature: Howard J. Mencer M.D.
Medical Examiner.
Date signed 7-29-47

VS 191

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G53893 Registered No. 178a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 3-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1407 Gough Street.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME THERESA M. YACOLA

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-20-8921

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: late Arthur Yacola.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 27 1926

8. AGE: Years	Months	Days	If less than one day
20	10	2	hr. min.

9. Birthplace: Baltimore Md.
(Town, county, and state)

10. Usual Occupation: Office Secretary

11. Industry or business: Nat. B. Co.

FATHER
12. Name: Dominic Di Angelo
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden Name: Mary Ferracci
15. Birthplace: Baltimore Md.

16 (a) Informant: Dominic Di Angelo (Br
(b) Address: 406 S. Exeter St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 1st 1947 (month) (day) (year)
(c) Cemetery or crematory: Baltimore National
Location: 5501 Frederick Ave

18 (a) Funeral director: Joseph Dallas Sons
(b) Address: 52 N. Morley St.

19 (a) (b) (Date rec'd by registrar) Huntington Hillsmeeting

VS 151

MEDICAL CERTIFICATION a

20. DATE OF DEATH July 29, 1947, at 11.25 M

21. I certify that I took charge of the remains described above, held an partial autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Asphyxiation

Due to: Illuminating Gas

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-29-47 at 11 a. M. 3/1
(b) Where did injury occur? 1407 Gough St. Baltimore, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Gas burners on, unlit Stove

23. Signature: Howard J. Sheridan M.D.
Medical Examiner.
Date signed 7-29-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 567

Registered No. G53894

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County CECIL
(c) City or town Rising Sun, R.F.D.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Herman C. Britton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	wh	

6 (b) Name of husband or wife Jessie Britton
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) 1 Jan 1893

8. AGE: Years	Months	Days	If less than one day
54	6	29	hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Store Keeper

11. Industry or business

FATHER
12. Name Nathan Britton
13. Birthplace North Carolina

MOTHER
14. Maiden Name Mary Britton
15. Birthplace North Carolina

16 (a) Informant Jessie Britton
(b) Address Rising Sun Md.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Aug 3 1947 (month) (day) (year)
(c) Cemetery or crematory Brookview
Location Rising Sun Md.

18 (a) Funeral director J. E. Tyson
(b) Address Rising Sun Md

19 (a) July 30 1947 (b) Registrar Hunting for Williams

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 July 1947, at 2.40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 14 July 1947 to 30 July 1947, and that I last saw him alive on 30 July 1947.

Immediate cause of death	Duration
Pulmonary embolism	
Due to	
Due to	
Other Conditions epidural tumor & paralysis (Include pregnancy within 3 months of death)	well

Date of operation 17 July 1947

Major findings of operation: Epidural tumor at 9th Thor

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. T. McGregor M. D.
Address Md. Gen. Hosp. Date signed 30 July 1947

X

G53895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

Registered No. G53895

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 101 Annabel Ave
(c) Hospital or institution: 25
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 101 Annabel Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Alida M. Merrill 61

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Maurice C.

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Oct 25, 1877

8. AGE: Years	Months	Days	If less than one day
69	9	3	hr. min.

9. Birthplace New York State (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Wm Lee Whitney
13. Birthplace N.Y.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr Maurice Merrill
(b) Address 101 Annabel Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/31/47 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Washington Blvd

18 (a) Funeral director John J Denny Inc
(b) Address 719 Light St.

19 (a) JUL 31 1947 (Date rec'd by Reg.) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28th 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1947, to July 28 1947, and that I last saw her alive on July 23 1947.

Immediate cause of death	Duration
Chronic Myocarditis	6 mo.
Due to Arteriosclerotic Heart Disease	4 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P. J. Innaldi M.D.
Address 4609 Gwynn Falls Pkwy. Date signed 7-28-47 M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53896

BALTIMORE CITY HEALTH DEPARTMENT

HERN CERTIFICATE OF DEATH 1947

Registered No. G53896

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline Street
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 days
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 1424 E. Oliver St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth E. Herne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Arthur G. Herne dead
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/28/1874?

8. AGE: Years 70 | Months 7 | Days 1 | If less than one day ..... hr. ..... min.

9. Birthplace England (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER
12. Name ? Cook
13. Birthplace England.

MOTHER
14. Maiden Name ? [redacted] ?
15. Birthplace England.

16 (a) Informant Douglas G. Herne
(b) Address 2018 Englewood Ave

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 8/1/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) JUL 31 1947 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/29/47 19..., at 6:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1/47 to 7/29/1947 and that I last saw h[illegible] alive on 7/29/47

Immediate cause of death	Duration
Respiratory + Cardiac Failure	
Due to Toxemia	
Due to Ovarian Carcinoma Abdominal Carcinomatosis	
Other Conditions Intestinal Obstruction	

(Include pregnancy within 3 months of death)

Date of operation 7/2/47

Major findings of operation: Abdominal Carcinomatosis, Int. Obstr.

of autopsy Abdominal Carcinomatosis

PHYSICIAN
Underline the cause to which it should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Anthony F. DiPaula, M.D.
Address St. Joseph's [illegible] Date signed 7/29/47

Huntington Williams, M.D.

X

G53897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 830

Registered No. G53897

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1102 East 36th Street
(c) Hospital or institution: 9:3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1102 East 36th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Henry Holthaus

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-18-9778

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Lillie Otto
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1866

8. AGE: Years	Months	Days	If less than one day
81	-	1	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation C. P. A.
11. Industry or business

FATHER
12. Name John Holthaus
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Homer
15. Birthplace Maryland

16 (a) Informant Mr. Harry Gambrill
(b) Address 1102 East 36th Street

17 (a) burial (b) Date thereof 8/2/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) AUG 21 1947 Huntington, West Va.
(Date filed with Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30, 1947, at 10:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 18 1947 to July 30 1947 and that I last saw alive on 7/28 1947

Immediate cause of death Paralysis — Duration 6/17/47
Due to Cerebral Hemorrhage
Due to
Other Conditions old age
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? no While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature A. C. Hearn M. D.
Address 790 Fairmount Ave. Date signed 8/19/47

VS 150

G53898

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. G53898

Every item of information should be carefully supplied. Type or write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2915 Alvarado Square

(c) Hospital or institution: 27

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2915 Alvarado Square
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Wroten

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: James B Wroten

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 14 1863

8. AGE: Years 84 | Months 4 | Days 14 | If less than one day hr. min.

9. Birthplace: Baltimore
(Town, county, and state)

10. Usual Occupation: at home

11. Industry or business

FATHER 12. Name: John Rahn

13. Birthplace: Germany

MOTHER 14. Maiden Name: Don't know

15. Birthplace

16 (a) Informant: Mrs David Brown

(b) Address: 2915 Alvarado Square

17 (a) burail (Burial, cremation, or removal) (b) Date thereof July 31 1947 (month) (day) (year)

(c) Cemetery or crematory: Parkwood

Location: Balto Co Md

18 (a) Funeral director: Ullrich Funeral Home

(b) Address: 2008 Orleans St

JUL 31 1947
(Date rec'd by registrar)

Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1947, at 2P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1946 to July 28 1947 and that I last saw h alive on 19

Immediate cause of death	Duration
Carcinoma of Rectum.	
Due to obstruction	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Louis Krause M.D.

Address 1 E Chase St Date signed 7/29/47

G53899 BCHD 84497 BALTIMORE CITY HEALTH DEPARTMENT Registered No. G53899
GM 112396 CERTIFICATE OF DEATH V 159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE
(c) Hospital or institution: 22-2
Balto. City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 521 W. Barry ST. Z 30
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Taylor (Female)

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: C
6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July -22 - 1947

8. AGE: Years | Months | Days: 4 | If less than one day: hr. min.

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John W. Taylor
13. Birthplace N.C.

MOTHER
14. Maiden Name Emma Alston
15. Birthplace N.C.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) cremated (b) Date thereof 7-26-47
(Burial) cremation, removal) (month) (day) (year)
(c) ~~Cemetery~~ crematory Balto City Hosp
Location 4940 Eastern Ave

18 (a) Funeral director
Address
JUL 31 1947
19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July - 26 - 1947, at 6.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 23- 1947, to July- 26 1947, and that I last saw him alive on July 26 - 1947.

Immediate cause of death: Prematurity — Duration 4 Dy

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Prematurity

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lindell H. Becker M. D.
Address Balto City Hosp Date signed 7/28/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53900 B/# D84678 CWK-112389 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 159 Registered No. G53900

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 142
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Kapyla (Olga)

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23-1947

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Jacob Kapyla
13. Birthplace Finland

MOTHER
14. Maiden Name Olga Brandt
15. Birthplace New York

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Cremated (b) Date thereof 7-28-47 (month) (day) (year)
(c) Cemetery or crematory Balto City Hosp
Location 4940 Eastern Ave

18 (a) Funeral director
(b) Address

19 (a) [illegible] 1947 Huntington Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1947, at 3:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 23 1947, to July 25 1947, and that I last saw him alive on July 25 1947.

Immediate cause of death Pneumonia — Duration 2 Days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Arnold M Bach M. D.
Address Baltimore Date signed 7/28/47

G53901 B.C.# B-83964 CWK-112035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157 A

Registered No. G53901

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 11-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 16 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1114 N. Calvert Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Frazier-- (Louise)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9-1947

8. AGE: Years	Months	Days	If less than one day
		16	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name Louise Frezier
15. Birthplace West Virginia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 7-26-47 (month) (day) (year)
(c) ~~Cemetery~~ crematory Balto. City Hosp
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) JUL 31 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

A

20. DATE OF DEATH July 25 19 47, at 1:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 9 19 47 to July 25 19 47, and that I last saw h im alive on July 25 19 47.

Immediate cause of death	Duration
Hydrocephalus	16 day
Due to congenital	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Hydrocephalus

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lloyd H. Becker, M.D.
Address Balto City Hosp Date signed 7/31/47

G53902

BALTIMORE CITY HEALTH DEPARTMENT

Mary Wright CERTIFICATE OF DEATH 183A

Registered No. G53903

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 924 N. Mount St.
(c) Hospital or institution: 16-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) none
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 924 N. Mount St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Wright

3 (b) If veteran, name war No | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John Wright

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 29 1896

8. AGE: Years: 51 | Months: 3 | Days: 1 | If less than one day: hr. min.

9. Birthplace Alexandria Va (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs Roxie Russell
(b) Address 928 N. Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 30 - 47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn

18 (a) Funeral director Wm Brooks
(b) Address 1463 N. Carey St

19 JUL 31 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. (signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-30 1947 at 5:51 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-15 1947 to 7-30 1947 and that I last saw her alive on 7-29 1947.

Immediate cause of death	Duration
Cerebral hemorrhage	15 days
Due to	
Due to	
Other Conditions Hypertension + arthritis	unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 1029 N. Stricker Date signed 7-31-47

C53903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. C53903

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use no abbreviations; write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospital 1-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2120 E. Pratt
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS KRAVETZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years: 71 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Aaron
13. Birthplace Russia

MOTHER
14. Maiden Name Lena
15. Birthplace Russia

16 (a) Informant Ida Kravetz
(b) Address 2120 E Pratt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7-31-47 (month) (day) (year)

(c) Cemetery or crematory Herzog Herring Lyn
Location

18 (a) Funeral director Jack Leibig Inc
(b) Address 769 Eastern Ave

19 (a) JUL 31 1947
(Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-30- 1947, at 3A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/25/ 1947 to 7/31 1947 and that I last saw him alive on 7/30 1947

Immediate cause of death: Cardiac Failure — Duration

Due to Coronary sclerosis
myocardial fibrosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E J Weyman MD
Address Emerg Hosp Date signed 7/30/47 M.D.

G53904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

Registered No. G53904

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.H.
(b) Street address 4627 Asbury Ave
(c) Hospital or institution: 26-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4627 Asbury Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Huhn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Margaret

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Sept 21 1875

8. AGE: Years 71 yrs | Months 10 | Days 9 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER
12. Name John Huhn
13. Birthplace Germany

MOTHER
14. Maiden Name Dont Know
15. Birthplace Germany

16 (a) Informant Wm J Huhn
(b) Address 4627 Asbury Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 2 - (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans

19 JUL 31 1947 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/31 19 47 at 10 32 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of prostate
& Lung Metastases

Due to

Other Conditions Arteriosclerotic C.V
disease
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at A.M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Truhinski M.D.
Medical Examiner.
Date signed 7/31/47

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G53905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 A

G53905 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2107 Belair Road
(c) Hospital or institution: 81

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2107 Belair Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JAMES EDWARD THOMAS

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 212-05-8883A

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary (Dougherty) Thomas

6 (c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): July 22, 1880

8. AGE: Years 67 | Months 0 | Days 6 | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Straw Hat Blocker

11. Industry or business: Levy Co.

FATHER
12. Name: Samuel Thomas
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Vianna Long
15. Birthplace: Maryland

16 (a) Informant: Mrs. Mary T. Thomas
(b) Address: 2107 Belair Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 7/31/47 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) (b) (Date received by registrar) (Registrar)

JUL 31 1947

V S 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH July 28, 1947, at 10.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7 July 1947 to 28 July 1947; that I last saw him alive on 28 July 1947.

Immediate cause of death: Carcinoma right kidney & generalized Metastasis — Duration: Feb-47

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Chas T. Edwards M. D.

Address: 2746 The Alameda Date signed: July 31 - 47

G53906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V-13B

G53906
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 160 David Hill Ave.
(c) Hospital or institution: 14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 160 David Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Evelyn Madeline Burrell

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19, 1927

8. AGE: Years 20 | Months 3 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William Burrell
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Anderson Mc Williams
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Lucy Browns
(b) Address 703 Harlem Ave.

17 (a) Burial (b) Date thereof Aug. 4, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Hall
(b) Address 631 David Hill Ave.

19 (a) Aug 3 1947 (b) Date received by registrar Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/29 1947, at 3.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/15 1947, to 7/29 1947, and that I last saw h[illegible] alive on 7/29 1947

Immediate cause of death Pulmonary edema

	Duration
Due to Myocardial insufficiency	10 days
Due to Pulmonary T.B.	?
	?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank Lawrence M. D.
Address 400 W. Lafayette Ave. Date signed 7/30/47

G53907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1469 Brown G53907

Registered No.

Every item of information should be carefully supplied. The cause of death clearly and legibly. Physicians: please write the correct age is especially important. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Raynor & Rutland Ave.

(c) Hospital or institution: West Baltimore General Hospital 9-9

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1701 Harford Ave. Balt. N. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Cecilia J. Brown

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	Widowed

6 (b) Name of husband ~~or wife~~ John Wesley Brown

6 (c) ~~If alive, give age~~ years

7. Birth date of deceased (mo., day, yr.) 17 January 1847

8. AGE: Years	Months	Days	If less than one day
100	6	13	hr. min.

9. Birthplace Baltimore City Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Andrew Berenger

13. Birthplace Baltimore City

MOTHER

14. Maiden Name Sara Letsinger

15. Birthplace Baltimore Maryland

16 (a) Informant Boyd E. Brown

(b) Address 2500 Edmonton Avenue

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Aug 2-47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Frederick Ave.

18 (a) Funeral director Joseph F. Condon, Jr.

(b) Address 4017 E. Franklintown Rd.

(c) Filed 1947 (b) Rec'd by reg. Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 July 1947, at 12 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7 July 1947 to 30 July 1947 and that I last saw her alive on 30 July 1947

Immediate cause of death	Duration
Cardiac failure	
Due to Arteriosclerotic cardio-vascular disease	
Due to	
Other Conditions Intertrochanteric fracture right hip-fall (Include pregnancy within 3 months of death)	

Date of operation 8 July 47

Major findings of operation: Fracture intertrochanteric right femur.

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, ~~suicide, or homicide~~ Accident 9-9

(b) Date of occurrence 6 July 47 at 1 P.M.

(c) Where did injury occur? Balt. city Md. (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? At home While at work? (Specify type of place) Fell on floor

(e) Means of injury Fell & fractured right femur

23. Signature John E. Rovsing

Address West Balt. Gen. Hosp. Date signed 30 July 47 M. D.

Howard J. Mencken, M.D.

G53908 LW 11X147

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 133 A

G53908 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County BALTO
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4111 Washington Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Gardner (George Francis Gardner)

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Mollie E. Gardner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1876

8. AGE: Years 70 | Months 10 | Days 10 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Retired Farmer

11. Industry or business

FATHER
12. Name George Gardner, Sr.
13. Birthplace Md.

MOTHER
14. Maiden Name Nerva Disney
15. Birthplace Md.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/2/47 (month) (day) (year)
(c) Cemetery or crematory Friendship Cem.
Location A. A. Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JUL 31 1947 (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1947, at 1:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 14 1947, to July 30 1947, and that I last saw h[illegible] alive on July 30 1947

	Duration
Immediate cause of death: Bronchopneumonia	2 days
Due to: Ulcerative Colitis	yrs.
Due to: Malnutrition	yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Bronchopneumonia, Ulcerative Colitis, Pyelonephritis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edgar Beahan

Address Balto City Hosp Date signed 30 Jul 47 M. D.

G53909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

G53909 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 508 Oxford St.
(c) Hospital or institution: 17-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 508 Oxford St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Katherine Cooper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 8, 1892

8. AGE: Years	Months	Days	If less than one day
54	10	21	..hr. ..min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-4-47 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Balto. Maryland

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (b) (Date rec'd by registrar) Washington Metropolitan Mortuary

JUL 31 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29, 1947 at 7 30 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from July 26, 1947 to July 29, 1947 (19..) and that I last saw ... alive on July 26, 1947

Immediate cause of death: Acute Dilatation of Heart — Duration: 3 months

Due to: Bronchitis — Duration: 3 months

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 1717 [illegible] Date signed 7/30/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45B

Registered No. G53910

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2040 E. Fayette St
(c) Hospital or institution: 6-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2040 E. Fayette St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret K. LeCompte

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	widowed

6 (b) Name of husband or wife James A. LeCompte
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 2 - 1881

8. AGE: Years	Months	Days	If less than one day
66	4	28	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER 12. Name John Arata
FATHER 13. Birthplace Penna

MOTHER 14. Maiden Name Katherine Connolly
MOTHER 15. Birthplace Baltimore

16 (a) Informant Thomas Connors
(b) Address 2040 E. Fayette St

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 8 1 47 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore

18 (a) Funeral director Philip Herwig Sons
(b) Address 1924 Orleans St.

19 (a) JUL 31 1947 (Date rec'd by registrar) (b) Huntington Williamsport Md.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3 Jan. 1947 to 30 July 1947 and that I last saw h[illegible] alive on 25 July 1947

Immediate cause of death	Duration
Carcinoma tongue	12 mos.
Due to	
Due to	
Other Conditions Cervical metast.	6 mos.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Arthur D. Jurinski M.D.
Address 214 Medical Arts Bldg. Date signed 7/31/47

X

G53911

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 193D

Registered No. G53911

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age, especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N Carey St
(c) Hospital or institution: Good Samaritan Home 16-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 811 N Monroe St (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Fannie C Dalby

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. ~~Sex~~	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15 - 1863

8. AGE: Years	Months	Days	If less than one day
83	10	15	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name William T Dalby
13. Birthplace Va

MOTHER
14. Maiden Name Jane Dunway
15. Birthplace Va

16 (a) Informant Alice Roberts
(b) Address 811 N Monroe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-1-47 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md

18 (a) Funeral director Grant H Leach
(b) Address 814 N 36th St

19 JUL 31 1947 (Date rec'd by registrar) by Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1947, at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947 to July 29 1947, and that I last saw h[illegible] alive on July 29 1947.

Immediate cause of death: Acute Cardiac failure. — Duration 2 days

Due to Arteriosclerotic heart disease — Duration 4 years.

Due to —

Other Conditions Hypertension Arteritis — Duration many years

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Charles Townsend Jr M.D.
Address 920 W. Lombard St. Date signed July 31 1947.

G53912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 99

Registered No. G53912

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Ave.
(c) Hospital or institution: Maryland Gen'l. Hosp. 17-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town) 508 W. Franklin St.
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert V. Biggs

3 (b) If veteran, name war: World War #2
3 (c) Social Security Account No. 218-09-5752

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1911

8. AGE: Years 35 | Months 10 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Laboratory Technician
11. Industry or business Bathlehem Steel Co.

FATHER
12. Name Robert C. Biggs
13. Birthplace Rock Ridge, Md.

MOTHER
14. Maiden Name Alice B. Worley
15. Birthplace Balto., Md.

16 (a) Informant Mr. Bruce Biggs
(b) Address 3923 Colborne Rd. 29

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/2/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto. Williams, Md.

19 (a) JUL 31 1947 (Date rec'd by registrar) (b) Huntington Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/30 1947 at 5 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/12 1947 to 7/30 1947 and that I last saw h.e alive on 7/30 1947

Immediate cause of death M.A. Pulmonary embolism — Duration

Due to — Duration

Due to — Duration

Other Conditions 99-1 — Duration: over

(Include pregnancy within 3 months of death)

Date of operation 7/12/47

Major findings of operation: Mesenteric thrombosis

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence At M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John E. Miller M. D.
Address Md. Gen'l. Hosp. Date signed 7/30/47

G53913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G53913

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2018 Orleans St.
(c) Hospital or institution: 6-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2018 Orleans St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD CHANEY

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widower

6 (b) Name of husband or wife: Elizabeth Young Chaney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct. 9, 1866

8. AGE: Years 80 | Months 9 | Days 22 | If less than one day ..... hr. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: baker (retired)

11. Industry or business

FATHER
12. Name: John Chaney
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Unknown

16 (a) Informant: Mr. Harry Chaney
(b) Address: 1920 Edmondson Ave.

17 (a) Burial (b) Date thereof 8/2/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) AUG 1 1947 (b) Huntington for Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31, 1947, at 6:00a M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947 to July 31 1947 and that I last saw him alive on July 30 1947

Immediate cause of death: Uraemia — Duration: 7 days
Due to: Chr. Nephritis
Hypertension
Due to:
Other conditions: Carcinoma of bladder ?
with metastases
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature: Earl F. Griffith M. D.
Address 2002 E. Baltimore Date signed 7/31/47

G53914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131A

Registered No. G53914

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1522 E Chase st
(c) Hospital or institution: 8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1522 E. Chase st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Jane Goldsbough

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	colored	widowed

6 (b) Name of husband or wife Frank Goldsbough
6 (c) If alive, give age Years

7. Birth date of deceased (mo., day, yr.) Sept-4-1873

8. AGE: Years	Months	Days	If less than one day
73	10	25	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Ludonia M Bell
(b) Address 1852 Lorman st

17 (a) Buried (b) Date thereof July 31-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Baltimore Md

18 (a) Funeral director Miss Ida Bailey
(b) Address 1421 E. Jefferson st
(Signature or address of undertaker) Huntington Williams Md

JUL 31 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July-29 1947, at 9:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/15 1947, to 7-29 1947 and that I last saw her alive on 7-28 1947.

Immediate cause of death	Duration
hypertensive cardio-renal disease	approx 5 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature X Rayner Browne

Address 1500 E. Madison St Date signed 7-30-47

G53915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

DOMBROWKE 61

Registered No. G53915

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 1-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 909 S. Potomac St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Frank Wombrawka.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Mary
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) 10-11-87

8. AGE: Years	Months	Days	If less than one day
59	9	20	hr. min.

9. Birthplace: Poland.
(Town, county, and state)
10. Usual Occupation: none.
11. Industry or business

FATHER
12. Name: Andrew Wombrawka.
13. Birthplace: Poland

MOTHER
14. Maiden Name: Katherine Ostachowska
15. Birthplace: Poland

16 (a) Informant: Records.
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/2/47 (month) (day) (year)
(c) Cemetery or crematory: Sacred Heart of Mary
Location: German Hill Rd

18 (a) Funeral director: John J. Duda
(b) Address: 2829 Hudson St.

19 (a) JUL 31 1947 (Date rec'd by registrar) Huntington Williams, M.D. (b) Address

MEDICAL CERTIFICATION

20. DATE OF DEATH: July - 31 1947, at 2.10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1947 to July 31 1947 and that I last saw him alive on July - 31 1947.

Immediate cause of death: Diabetes Mel (regulated) Extensively infected undermining decubitus ulcer, Myocard infarction, Generalized arteriosclerosis — Duration

Due to

Other Conditions: Benign Prost Hypertrophy

(Include pregnancy within 3 months of death)

Date of operation ② 7/29/47

Major findings of operation: ① Amputation L Leg ② Incis & Drain ulcer on Back

of autopsy: Not yet reported

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Thomas E. Van Metre M. D.
Address: J Hopkins Hosp Baltimore, Md Date signed 7/31/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C53916 111453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117A

Registered No. C53916

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 44 Days.
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3493 Hickory Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Millard Jackson

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-14-3599

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Katie M. Jackson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1893

8. AGE: Years	Months	Days	If less than one day
53	9	14	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Plumber
11. Industry or business

FATHER
12. Name Albert Jackson
13. Birthplace Md.

MOTHER
14. Maiden Name Addie Carr
15. Birthplace Md.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 2 1947 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Harford Co., Maryland

18 (a) Funeral director George Funeral Home
(b) Address 3631 Falls Road

JUL 31 1947 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1947 at 12 mid. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1947 to July 30 1947 and that I last saw him alive on July 30 1947.

Immediate cause of death Uremia — Duration 10 Days

Due to Renal Failure

Due to Incompatability of Blood Transfusion

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7/3/47

Major findings of operation: Marginal Ulcer — Gastro-Enterostomy

of autopsy: Not completed at time of this statement

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank S. Forrest M. D.
Address Baltimore City Hosp signed 7/30/47

PHYSICIAN

Underline the cause to which death should be attributed.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53917

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

√122 P

Registered No. G53917

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave & Madison St.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 186 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4010 Clifton Ave #16 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Meyers.

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 212-01-2061

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	~~Mar~~ Married

6 (b) Name of husband or wife Carrie M. Schooler
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) 1 May 1879

8. AGE: Years	Months	Days	If less than one day
68	2	29	~~hours~~ ~~min.~~

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business Dr. Pepper Bottling Co.

FATHER
12. Name John Jacob Meyers
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Carrie M. Meyers-Wife
(b) Address 4010 Clifton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/2/47. (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd. Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1 Harford Avenue

19 (a) JUL 31 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 July 1947, at 1 ~~P~~ A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8 Apr 1947 to 30 July 1947, and that I last saw ~~him~~ alive on 29 July 1947.

Immediate cause of death: Diabetic Coma — Duration: 1 day

Due to: Diabetes mellitus — 15 yrs.

Due to:

Other Conditions: Marasmic left ventral hernia.
(Include pregnancy within 3 months of death)

Date of operation 25 Feb 47

Major findings of operation: Small umbilical hematoma

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. Allan Gier M. D.
Address Md. Gen. Hosp. Date signed 30 July 47

VS 130

G53918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G53918

Registered No.

46E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 620 Allendale St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 620 Allendale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Thomas A. Gracie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sarah A. Gracie

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) August 11, 1881

8. AGE: Years 65 | Months 11 | Days 18 | If less than one day ... hr. ... min.

9. Birthplace: Eckhart, Mines, Md.
(Town, county, and state)

10. Usual Occupation: State Secretary of Md.

11. Industry or business: Jr. O. U. A. M.

FATHER
12. Name: Archibald Gracie
13. Birthplace: Eckhart Mines, Md.

MOTHER
14. Maiden Name: Mary Willison
15. Birthplace: Scotland

16 (a) Informant: Mrs. Sarah A. Gracie
(b) Address: 620 Allendale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 1, 1947 (month) (day) (year)
(c) Cemetery or crematory: Western Cemetery
Location: Baltimore, Md.

18 (a) Funeral director: E. Miles Lamoreaux
(b) Address: 4510 Liberty Heights Ave.

19 (a) (Date received by registrar) Huntington Williams M.D. Registrar

JUL 31 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1947, at 3.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1944 to July 29 1947.
and that I last saw him alive on July 28 1947.

Immediate cause of death: Edema of lungs — Duration: 3 hrs.

Due to: Cachexia — 3 mon.

Due to: Mixed cell Sarcoma of large intestines — 6 mos.

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation: May 1947
Major findings of operation: Mixed cell Sarcoma of large intestine
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Geo. E. Wilson M. D.
Address: 4100 Edmondson Ave. Date signed 7/30/47

G53919 — BALTIMORE CITY HEALTH DEPARTMENT — G53919

CERTIFICATE OF DEATH 182a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6006 York Road
(c) Hospital or institution
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6006 York Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME William D. Mibber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Minnie E. —

6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Dec. 13-1872

8. AGE: Years	Months	Days	If less than one day
75	3	17	____hr. ____min.

9. Birthplace New Bloomfield - Pa (Town, county, and state)

10. Usual Occupation Vault Custodian

11. Industry or business Md. Trust Co

FATHER — 12. Name Joseph Miller

13. Birthplace Pa

MOTHER — 14. Maiden Name Mary Brennan

15. Birthplace Pa

16 (a) Informant Mrs Minnie E. Miller

(b) Address 6006 York Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 2-47 (month) (day) (year)

(c) Cemetery or crematory East Harrisburg

Location Harrisburg - Pa

18 (a) Funeral director F. B. Wipperz & Son

(b) Address 1300 Eutaw Place

19 (a) ____ (b) Registered by registrar Huntington Williams, M.D. Registrar

AUG 1 1947

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 - 1947, at 11 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15- 47 to July 30 1947 and that I last saw him alive on 1947.

Immediate cause of death Bronchio-Pneumonia — Duration 2 days

Due to

Due to

Other Conditions Contract Hemorrhage — 5 days

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury

23. Signature Hugh A. Hanner M.D.

Address 11 East Chase St. Date signed 7/31/47

107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53920 G53920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs 6 mos 15 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3831 Sequoia Ave, Balto 15
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Wilhelmina Bender

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Married

6 (b) Name of husband or wife George Bender
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) July 9, 1882

8. AGE: Years	Months	Days	If less than one day
65	—	19	— hr. — min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Robert Schmidt
13. Birthplace Germany

MOTHER
14. Maiden Name Dorothea Miller
15. Birthplace Germany

16 (a) Informant Mr. George Bender
(b) Address 3831 Sequoia - Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 31 July 47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore - Md.

18 (a) Funeral director C. B. Tilbert & Son.
(b) Address 120 Eutaw Place
Baltimore, Md.

JUL 31 1947
(Date rec'd by registrar)
Clayton Williams, M.D.
Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/28/47 1947, at 10:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 23 1946, to July 28 1947, and that I last saw h alive on July 28 1947.

Immediate cause of death	Duration
Carcinoma of transverse Colon & Metastasis	1 yr 7 mo
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation April 1947
Major findings of operation: Carcinoma Colon
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury
23. Signature J. W. Duckworth
Address 1169 St Paul St Date signed 7/28/47 M. D.

G53921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

G53921 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 429 S. Bentalou St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 429 S. Bentalou St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth P. Murray

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife George C.
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) 12-4-1886

8. AGE: Years	Months	Days	If less than one day
60	7	25	____ hr. ____ min.

9. Birthplace Scotland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Joseph Brown
13. Birthplace Scotland

MOTHER
14. Maiden Name Agnes Hintha
15. Birthplace Scotland

16 (a) Informant Mr. George C. Murray
(b) Address 429 S. Bentalou St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 4-47 (month) (day) (year)
(c) Cemetery or crematory Bureau of Chicago
Location Springfield - Mass

18 (a) Funeral director F. A. Wippert & Son
(b) Address 1300 Eutaw Place-17

19 (a) (b) (Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29th 1947, at 11:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 25 1947 to July 29 1947, and that I last saw h.. alive on July 29 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	6 mos.
Due to —	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Morris B. Brenner M. D.
Address 54 S. Fulton Ave. Date signed 7-31 47

X

G53922

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G53922
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 151 Willard St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Adam J. YOUNGHANS

3 (b) If veteran, name war: W. W. II

3 (c) Social Security Account No. 216-05-4083

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 11/18/1899

8. AGE: Years	Months	Days	If less than one day
47 yrs	8	10	hr. min.

9. Birthplace Baltimore - Md
(Town, county, and state)

10. Usual Occupation BREWER

11. Industry or business Gunther Brew. Co

FATHER 12. Name Rudolph Younghans
13. Birthplace Germany

MOTHER 14. Maiden Name Katherine Schmidt
15. Birthplace Germany

16 (a) Informant Mrs Helen Rimbach
(b) Address 151 Willard St

17 (a) Burial (b) Date thereof Aug-1-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore - Md

18 (a) Funeral director F. B. Kippert & Son
(b) Address 1300 Eutaw Place

19 (a) 1 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1947, at 11 50 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 7/29/47

File No. C53923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 1947

Registered No. C53923

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Maryland Penitentiary
(c) Hospital or institution: 954 Forest St.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 4 9
(e) Length of stay in Baltimore (yrs., mos., or days) 2 4 9

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ?? Somerset
(c) City or town Chance
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Weldon Jones, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No. Unknown

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1926

8. AGE: Years 20 | Months 8 | Days 21 | If less than one day hr. min.

9. Birthplace Chance, Md (town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Weldon Jones, Sr.
13. Birthplace Chance, Md.

MOTHER
14. Maiden Name Virginia Holbrook
15. Birthplace Denton, Md.

16 (a) Informant Weldon Jones
(b) Address Upper Hill Md

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Aug 3 1947 (month) (day) (year)
(c) Cemetery or crematory Upper Hill
Location Upper Hill Md

18 (a) Funeral director Charles H Ward
(b) Address Madison Md

19 (a) Huntington Williams M.D. (Registrar)
(Date received by registrar) AUG 4 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1 1947, at A.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 24 1947, to Aug. 1 1947, and that I last saw him alive on Aug 1 1947.

Immediate cause of death	Duration
Dislocation of 5th Cervical vertebra	
Due to Execution by hanging	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 8-1-47 at 12 33 M
(c) Where did injury occur? Baltimore (City or town) Md. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Penitentiary While at work? (Specify type of place)
(e) Means of injury Execution by hanging

23. Signature Dr. Henry W. H. Hodges M. D.
Address Md. Penitentiary Date signed 8-1-47

X

G53924 AB-109810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G53924

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 23yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4114 Belvedere Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Samuel Swigert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20- 1879

8. AGE: Years 68 | Months 4 | Days 9 | If less than one day hr. min.

9. Birthplace Ill. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Swigert
13. Birthplace Penna.

MOTHER
14. Maiden Name Barbara Mennick or Nemick
15. Birthplace Ill.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 8-2-47 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Windsor Blvd

18 (a) Funeral director Wilhoyte Lodge Inc
(b) Address 1217 H Fort St

AUG 1 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1947, at 4.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-1 1947 to 7-28 1947 and that I last saw him alive on 7-28 1947.

	Duration
Immediate cause of death: Cardiac failure	
Due to: Cardiac decompensation	
Due to: Arteriosclerotic Cardiac Disease	
Other Conditions: Arteriosclerosis, gen. sen.	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Nuckols M.D.
Address Balto City Hosp Date signed 30 Jul 47.

G53925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G53925

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hosp. for Women of Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Ruxton (If outside city or town limits, write RURAL and give town)
(d) Street No. Carlton Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME: Sarah Elizabeth Ecker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	W.

6 (b) Name of husband or wife: Frank Ecker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15 1846

8. AGE: Years	Months	Days	If less than one day
61		17 15	hr. min.

9. Birthplace: Balto - Md. (Town, county, and state)
10. Usual Occupation: house wife
11. Industry or business

FATHER
12. Name: Isaac Krout
13. Birthplace: Balto - Md

MOTHER
14. Maiden Name: Sarah Hizer
15. Birthplace: Balto Md

16 (a) Informant: John Ecker
(b) Address: Ruxton - Md

17 Burial (Burial, cremation, or removal) (b) Date thereof 8/2/47 (month) (day) (year)
(c) Cemetery or crematory: Loms Creek
Location: Carroll Co Md

18 (a) Funeral director: Hellhorn & Son Inc
(b) Address: 1219 E Fayette St

AUG 1 1947 (Date rec'd by local registrar) (b) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1947, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 27 1947, to July 30 1947, and that I last saw h.r alive on July 30 1947.

Immediate cause of death	Duration
Cardiac Decompensation	
Due to Myocardial Infarction	
Due to Coronary Sclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Myocardial Infarction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature: George H. Lechlinger M. D.
Address: K. W. M. Date signed 7/30/47

X

C53926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

198 Registered No. C53926

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 954 Forrest St.
(c) Hospital or institution: Maryland Penitentiary
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 20
(e) Length of stay in Baltimore (yrs., mos., or days) 20

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Dorchester
(c) City or town Deals Island
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ross J. Abbott

3 (b) If veteran, name war World War II | 3 (c) Social Security Account No. Unknown

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4, 1922

8. AGE: Years 25 | Months 6 | Days 28 | If less than one day ... hr. ... min.

9. Birthplace Deals Island, Md. (Town, county, and state)

10. Usual Occupation Seaman

11. Industry or business

FATHER 12. Name William C. Abbott
13. Birthplace Dorchester County, Md.

MOTHER 14. Maiden Name Nora Robinson
15. Birthplace Dorchester County Md.

16 (a) Informant Penitentiary Records
(b) Address 954 Forrest Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-1-47 (month) (day) (year)

(c) Cemetery or crematory Salisbury
Location Salisbury, Md.

18 (a) Funeral director J. T. Holloway & Co.
(b) Address Salisbury, Md.

19 (a) [illegible] (b) AUG 1 1947 Huntingtown Williamsville, Md.
VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1 1947, at 7 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 24 1947, to Aug. 1 1947, and that I last saw him alive on Aug. 1 1947.

Immediate cause of death	Duration
Dislocation of 5th Cervical vertebra	
Due to Execution by hanging	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 8-1-47 at 12 16 M.
(c) Where did injury occur? Baltimore (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Penitentiary While at work? (Specify type of place)
(e) Means of injury Execution by hanging

23. Signature Henry W. Dorsey M. D.
Address Md. Penitentiary Date signed 8-1-47

G53927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

G53927

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4618 Asbury Ave.

(c) Hospital or institution:

76

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 4618 Asbury Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME K. WILHELMINA HINKER

3 (b) If veteran, name war

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife William Hinker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17, 1863

8. AGE: Years	Months	Days	If less than one day
83	9	13	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Christian Sinsz

13. Birthplace Germany

MOTHER

14. Maiden Name Margaret Stuck

15. Birthplace Germany

16 (a) Informant Mrs. Henry E. Hermann,

(b) Address 3914 Southern Ave., Balto.

17 (a) burial (b) Date thereof Aug. 2, 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Jerusalem Lutheran

Location Balto., Md.

18 (a) Funeral director Lasahn Funeral Home

(b) Address 7401 Belair Road

19 AUG 1 1947 Huntington Williams, M.D.
(Date rec'd by Reg.) (Signature of Registrar)

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30th, 1947, at 3:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1947 to July 30 1947 and that I last saw h[illegible] alive on July 28 1947

Immediate cause of death	Duration
Carcinoma of Stomach	1 year
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: No

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence None at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? What at work?
(Specify type of place)

(e) Means of injury

23. Signature L. K. Goodall M. D.

Address 706 Garfield Ave. Date signed 7-31 1947

7-31 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53928

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 46E

Registered G53928

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Del. (b) County
(c) City or town Wilmington
(If outside city or town limits, write RURAL and give town)
(d) Street No. 800 W. 22nd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sallie Tofkes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Victor E. Tofkes

6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) 9-26-94

8. AGE: Years 52 | Months 10 | Days 5 | If less than one day ____ hr. ____ min.

9. Birthplace Conn.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Isaac Cohen
13. Birthplace Austria

MOTHER 14. Maiden Name Mary Butters
15. Birthplace Austria

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (b) Date thereof July 1-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Wilmington
Location Delaware

18 (a) Funeral director John D. Mitchell
(b) Address 1900 Eutaw Pl.

19 (a) (Date rec'd by local registrar) (b) Huntington Williams, M.D.

AUG 1 1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-31-1947 at 8:27 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-27 1947 to 7-31 1947 and that I last saw her alive on 7-31-1947.

Immediate cause of death: Shock — Duration: 3 hrs.
Due to: Operation (Pneumonectomy) for metastasis
Due to: Carcinoma of Sigmoid — Duration: 7 yrs.
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 7-31-47
Major findings of operation: Ca (Metastatic)
of autopsy: 11 Lung

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. B. Morow M. D.
Address 1414 Date signed 7-31-47

X

C53929 TENNIS T. PHILLIPS

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH -13B

Registered No. C53929

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 414 N. Parrish St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 414 N. Parrish St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Tennis T. Phillips

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	married

6 (b) Name of husband or wife Eloneva
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-7-1917.

8. AGE: Years	Months	Days	If less than one day
30	4	21	hr. min.

9. Birthplace Suffolk Va.
(Town, county, and state)
10. Usual Occupation Laborer.
11. Industry or business

FATHER 12. Name Edward Phillips.
13. Birthplace Virginia

MOTHER 14. Maiden Name Mattie Copeland.
15. Birthplace Virginia

16 (a) Informant Mrs. Eloneva Phillips
(b) Address 414 N. Parrish St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 1, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) AUG 1 1947 (Date received by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1947 at 5:10 P M

21. I certify that death occurred on the date above stated, that I attended deceased from July 26 1947 to July 28 1947, and that I last saw deceased alive on July 28 1947.

Immediate cause of death	Duration
Pulmonary T.B.	2 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify one of place)
(e) Means of injury

23. Signature H. H. Broome M. D.
Address 714 Broome Date signed July 29 1947

G53930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

G53930 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 521 N. Fremont Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 521 N. Fremont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jeannette Washington.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 27, 1889

8. AGE: Years 57 | Months 11 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housekeeper.

11. Industry or business

FATHER
12. Name George Washington
13. Birthplace Md.

MOTHER
14. Maiden Name Roberta Bowen
15. Birthplace Md.

16 (a) Informant Mrs. Marie Tyler.
(b) Address 4 N. Fremont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 2, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Ambrum
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (c) AUG 1 1947 (Date rec'd by reg.) Katie R. Williams, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 9 1946, to July 30 1947 and that I last saw h ve alive on 29 1947.

Immediate cause of death: Carcinoma of Uterus & metastasis.
Duration: 2 yr. 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jno. D. Sullivan M.D.
Address 511 N. Schroeder St. Date signed 7/31/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

✓ G53931 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 801 Preica St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 801 Preica St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clarence Chew

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Hattie Chew
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20, 1887

8. AGE: Years 60 | Months 1 | Days 10 | If less than one day hr. min.

9. Birthplace Calvert Co., Md.. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry Chew
13. Birthplace Calvert Co. Md..

MOTHER
14. Maiden Name Comelius ?
15. Birthplace Calvert Co. Md.

16 (a) Informant Virginia Chew
(b) Address Calvert Co., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 3 1947 (month) (day) (year)
(c) Cemetery or crematory Western Chapel
Location Calvert Co. Md

18 (a) Funeral director Mrs Katie G. Williams
(b) Address 322 N. Schroeder St.

19 AUG 1 1947 (Date rec'd by Registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1947 at 6.10 P M

21. I certify that death occurred on the date above stated, that I attended deceased from July 27 1947 to July 30 1947 and that I last saw him alive on July 30 1947

Immediate cause of death: Cerebral Hemorrhage — Duration 3 dys

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address Date signed 8/1/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53932

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92B

G53932 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 31 (If outside city or town limits, write RURAL and give town)
(d) Street No. 315 No. Broadway (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Clara Dell

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Mr. Lee. Dell
6 (c) If [illegible] years

7. Birth date of deceased (mo., day, yr.) Dec. 9 1884

8. AGE: Years 62 | Months 9 | Days 21 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Mr. Geo. Berlin
13. Birthplace Germany

MOTHER
14. Maiden Name Miss Louise Fisk
15. Birthplace Maryland.

16 (a) Informant Mrs. Clara Dell
(b) Address 315 No Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/2/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Allen Funeral Home
(b) Address 2008 Gilham St.

19 (a) Date rec'd by Local Registrar AUG 1 1947 (b) Huntington Wills Registrar, Md.

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/30/47 19 , at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 30 1947 to 7/30/47, and that I last saw h[illegible] alive on 7/30/47.

Immediate cause of death	Duration
Cardiac Failure	
Due to Hypertrophy, Left Ventricle (Chronic Stenosis)	
Due to Arteriosclerosis, Chronic	
Other Conditions Contributing Thrombosis left popl.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Venous ligation bilateral
of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. P. Austrian
Address Church Home & Hosp. Date signed 7/30/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 106B

Registered No. G53933

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 N Gay St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 N Gay St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick W. Schmidt

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Henrietta L. Schmidt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 11 1865

8. AGE: Years	Months	Days	If less than one day
82	4	20	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation
11. Industry or business Tobacconist

FATHER
12. Name Frederick W. Schmidt Sr.
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Clauss
15. Birthplace Germany

16 (a) Informant Mrs Irene L Schmidt
(b) Address 1701 N Gay St

17 (a) Burial (b) Date thereof Aug. 4 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem City
Location

18 (a) Funeral director Leeric Funeral Home
(b) Address 2005 Orleans St

AUG 1 1947 Huntington Williams Jr.
(Date rec'd by Reg.) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1947, at 10 A.M. CS

21. I certify that death occurred on the date above stated; that I attended deceased from 7-29 1947 to 7-31 1947 and that I last saw him alive on 7-30 1947.

Immediate cause of death	Duration
Heart Failure	1 day
Due to Chronic Bronchitis	6 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William L. Jenny
Address 3025 Belair Rd Date signed 8-1-47

G53934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G53934

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LAFAYETTE AND JOHN ST.
(c) Hospital or institution: WOMEN'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 18 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State West Virginia County
(c) City or town HALL TOWN (If outside city or town limits, write RURAL and give town)
(d) Street No. NONE (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ANGELA (NONE) HARRISON

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife FRANK HARRISON

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 20 AUGUST 1877

8. AGE: Years 69 | Months 11 | Days 11 | If less than one day ....hr. ....min.

9. Birthplace WASHINGTON D.C. (Town, county, and state)

10. Usual Occupation NW

11. Industry or business HOME

FATHER
12. Name DONALD MACLEOD
13. Birthplace UNKNOWN

MOTHER
14. Maiden Name HARRIETT GIBSON
15. Birthplace CHESTER PENNA.

16 (a) Informant FRANK HARRISON
(b) Address MORRIS AVE, TOWSON, MD.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/1/47 (month) (day) (year)
(c) Cemetery or crematory
Location Charles Town, W. Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Filed by registrar AUG 1 1947 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 31 July 1947 at 2:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 16 1947, to 31 July 1947, and that I last saw HER alive on 31 July 1947

Immediate cause of death	Duration
CARDIAC FAILURE	
Due to MYOCARDIAL INFARCTION	2 10 Days
Due to ARTERIOSCLEROTIC HEART DISEASE	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Donald B. Gibson, Jr. M.D.
Address Women's Hospital Date signed July 31 1947

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C53935 COR. 53935 CERT

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 87B

Registered No. C53935

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 621 Saratoga St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 621 Saratoga St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sarah Jackson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 7, 1874

8. AGE: Years 72 | Months 11 | Days 23 | If less than one day hr. min.

9. Birthplace Georgia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name unknown
13. Birthplace unknown

MOTHER 14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Estella Dawson
(b) Address 621 W. Saratoga St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-2-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location C. C. Co. Maryland

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (Date rec'd by local registrar) (b) Huntington Williams, M.D.

AUG 1 1947

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 4 1946 to July 30 1947 and that I last saw h. alive on July 30 1947

I. Cause of death: Meningitis — Duration: 3 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Adolphus Halstead

Address 63 W. Preston St. Date signed July 31 1947 M. D.

X

G53936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 109a

G53936 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 913 N. Bond St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days) 15 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 913 N. Bond St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Belle Gorsage Toppin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Frank Toppin

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) 1919

8. AGE: Years 28 | Months | Days | If less than one day: hr. min.

9. Birthplace Littleton N. C.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Eli Goings

13. Birthplace Littleton, N. C.

MOTHER 14. Maiden Name Lue Watkins

15. Birthplace Littleton N. C.

16 (a) Informant Lindsey Brown

(b) Address 913 N. Bond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 3. 1947 (month) (day) (year)

(c) Cemetery or crematory

Location Littleton, N. C.

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Brantly Ave

AUG 1 1947 Date received Registrar Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1947 at 8 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 7 July 1947 to 29 July 1947, and that I last saw h[illegible] alive on July 29 1947.

Immediate cause of death	Duration
(a) Uraemia Pneumonia	4 wks
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stanford D. Innsenden M. D.

Address 2309 Druid Hill Ave Date signed 7-29-47

G53937 ✓ G53937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital 56
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5201 Frederick Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ezra H Kirk

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Lula P. Fetters
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Dec 13 1869

8. AGE: Years	Months	Days	If less than one day
57	7	17	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Ret RR Conductor
11. Industry or business Transportation

FATHER
12. Name George Kirk
13. Birthplace West Virginia

MOTHER
14. Maiden Name Alice Wells
15. Birthplace West Virginia

16 (a) Informant Mrs Lydia Kirk
(b) Address Baltimore Md.

17 (a) Burial (b) Date thereof Aug 3 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick Md

18 (a) Funeral director C. H. Fleiter Bro
(b) Address Brunswick Md

19 (a) (Date received by registrar) Washington Co. Williams, M.D. Registrar

Aug 1 1947
vs 190

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1 1947 at 4:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1947 to August 1 1947 and that I last saw he alive on August 1 1947

Immediate cause of death	Duration
Carcinomatosis	
Due to Bronchogenic Carcinoma	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. a Hughtower M. D.
Address University Hospital Date signed 8-1-47

X

G53938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164a

✓ G53938 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 234 N. Luzerne Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 234 N. Luzerne Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME TILLIE PRODANCHEK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~or wife~~: Zachary

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) ? 1898

8. AGE: Years 49 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Austria
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Panko Rakoczy
13. Birthplace ? Unknown

MOTHER
14. Maiden Name Helen Shulka
15. Birthplace ? Unknown

16 (a) Informant Zachary Prodanchek
(b) Address 234 N. Luzerne Ave

17 (a) Burial (b) Date thereof 8-2-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Trinity Orthodox
Location Stony Run Md.

18 (a) Funeral director George A. Weber
(b) Address 705 S. Ann St

(c) (Date 1947) (Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1947, at 2 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Asphyxiation by hanging

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-31-47 at Between 12:30 and 1:30 P. M.
(b) Where did injury occur? 234 N. Luzerne Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Hanging from rafter in cellar by piece of cloth

23. Signature George A. Merrill M.D.
Medical Examiner.

Date signed 7/31/47

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G53939

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1312

Registered No. G53939

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Dallas St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 ?
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 N. Dallas St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Flossie R Smith Reynolds

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C.	W

6 (b) Name of husband or wife Reynolds
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years	Months	Days	If less than one day
54.			hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Dabney Minor
13. Birthplace Va

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Va

16 (a) Informant Estella Wyche
(b) Address 1400 N. Dallas Ste

17 (a) Burial (b) Date thereof 8/1/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A. A. Co. Md

18 (a) Funeral director Robert E Williams
(b) Address 1515 McElderry St

AUG 1 1947 (b) Huntington Williams, Mgr
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1947, at 3:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947 to July 29 1947, and that I last saw h alive on July 29 1947

Immediate cause of death Pulmonary Edema — Duration 2 days

Due to Mitral Regurgitation — Duration Couple mos.

Due to

Other Conditions Chronic Nephritis
& Uremia
(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation

of autopsy? No

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ralph J Young M. D.
Address W 29 & Monument Date signed

PHYSICIAN
Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

92 B

G53940

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G53940

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5107 IVANHOE AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE MD (If outside city or town limits, write RURAL and give town)
(d) Street No. 5107 IVANHOE AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MRS EMELINE KNIGHT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 16 MAY 1851

8. AGE: Years	Months	Days	If less than one day
96	2	15	hr. min.

9. Birthplace MT. CLARE W. VA. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name VALENTINE KNIGHT
13. Birthplace W. VA.

MOTHER
14. Maiden Name MARIA HOLDEN
15. Birthplace W. VA.

16 (a) Informant MRS PRUDENCE TRIPLETT
(b) Address 5107 IVANHOE AVE

17 (a) B (Burial, cremation, or removal) (b) Date thereof 8 2 1947 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location BALTIMORE MD

18 (a) Funeral director A. REILEY SLADE
(b) Address 4907 YORK RD

19 AUG 1 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 19 47, at 2 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from JULY 19 1947 to July 31 1947 and that I last saw h alive on 19

Immediate cause of death	Duration
(a) Coronary Embolism	7 yrs.
Due to Arteriosclerosis	6 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. W. Thomas M.D.
Address 3156 Kenyon Ave Date signed Aug 1 47

J. W. THOMAS, MD X

G53941

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 109a

Registered No. G53941

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 301 Northfield Place
(c) Hospital or institution: 7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County -
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 802 N. Patterson Park ave. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MICHAEL B. O'CONNOR

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	Married

6 (b) Name of husband or wife Jessica Nightman O'Connor
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Apr. 12, 1874

8. AGE: Years	Months	Days	If less than one day
73	3	18	hr. min.

9. Birthplace Martinsburg, W. Va. (Town, county, and state)
10. Usual Occupation Telegraph Operator
11. Industry or business B. & O. R.R.

FATHER
12. Name Maurice O'Connor
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Kavanaugh
15. Birthplace Ireland

16 (a) Informant Mrs. Jessica O'Connor
(b) Address 802 N. Patterson Park ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/2/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Evans & Son Inc.
(b) Address 118 N. Mt. Royal Ave.

19 (a) [illegible] 1947 (b) Filed by registrar Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1947 at M

21. I certify that death occurred on the date above stated that I attended deceased from [illegible] 19[illegible] to July 30 1947 and that I last saw h[illegible] alive on July 29 1947.

Immediate cause of death	Duration
Pneumonia, atypical	
Due to Left base 2 mo. ago	
at base 1 wk ago	
Due to	
Other Conditions, Chr. Myocardial infarction	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature [illegible] M. D.
Address 1 E. Chase Date signed 8/1/47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G53942

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2615 Llewelyn Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2615 Llewelyn Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eva Katherine Walker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Adam C. Walker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct-23-1871

8. AGE: Years 75 | Months 9 | Days 8 | If less than one day hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frederick Boecker
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Anna B. Spieger
15. Birthplace Germany

16 (a) Informant Anna B. Boecker
(b) Address 2615 Llewelyn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-2-47 (month) (day) (year)
(c) Cemetery or crematory Emanuel Cem
Location Edmondson Ave

18 (a) Funeral director John E. Oliver
(b) Address 243 S. E.

19 (a) Date rec'd by Registrar AUG 1947 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-31-1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9 July 1946 to 30 July 1947 and that I last saw h[illegible] alive on 30 July 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	9 mos.
Due to Arteriosclerosis, generalized	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard Poltrack M. D.

Address 1513 N. Milton Ave Date signed Aug 4 47

X

G53943

BALTIMORE CITY HEALTH DEPARTMENT

Lover Kamp CERTIFICATE OF DEATH 1131a

G53943 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rutland + Monument
(c) Hospital or institution:
Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give county)
(d) Street No. 414 N. Rose St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lowenkamp, Clara

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22 - 1877

8. AGE: Years 70 Months Days 9 Under 1 day hr. min.

9. Birthplace Illinois
(Town, county, and state)

10. Usual Occupation Housework.

11. Industry or business

FATHER
12. Name Fritz Obermark
13. Birthplace Germany

MOTHER
14. Maiden Name Mary McEdefen
15. Birthplace Illinois

16 (a) Informant Emma Zeigler
(b) Address 414 N. Rose St.

17 (a) Burial (b) Date thereof Aug. 4-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Westgrolis Ill.

18 (a) Funeral director John R. Miller
(b) Address 2524 Jefferson St.

19 (a) (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

AUG 1 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/1 19 47, at 12 29 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/30 19 47 to 7/31 19 47, and that I last saw her alive on 7/31 19 47

Immediate cause of death	Duration
Cerebral hemorrhage	2 days
Due to Cardiovascular renal disease	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cerebral Hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address Sinai Hosp. Date signed 8/1/47 M. D.

X

G53944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G53944

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4702 HARFORD AVE.
(c) Hospital or institution:
Harford Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 YEARS
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1520 HOMESTEAD STREET.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET T. WEBSTER. (Maggie)

3 (b) If veteran, name war -

3 (c) Social Security Account No. -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Thomas F. Webster
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1871

8. AGE: Years	Months	Days	If less than one day
76	2	19	hr. min.

9. Birthplace Somerset Co., Md.
(Town, county, and state)

10. Usual Occupation -

11. Industry or business

FATHER
12. Name - Williams
13. Birthplace Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mr. James H. Windsor
(b) Address 2741 Winchester St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/2/47 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Cem.
Location Howard Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) AUG 1 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

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MEDICAL CERTIFICATION P

20. DATE OF DEATH JULY 30 1947 19..... at 11.30 P

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT 5 1946 to JULY 30 1947 and that I last saw her alive on JULY 30 47.

Immediate cause of death	Duration
APOPLEXY. JULY 15	1947.
Due to CHRONIC MYOCARDITIS	1946.
Due to ARTERIOR SCLEROSIS	1946.
Other Conditions HYPERTENSION.	

(Include pregnancy within three months of death) NONE
Date of operation
Major findings of operation: NONE
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward Odenwelder M.D.
Address 3013 ST PAUL STREET Date signed JULY 31 1947

G53945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G53945 Registered No. 1112

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1516 N. Fulton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1516 N. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME RAYMOND H. LLOYD

3 (b) If veteran, name war: none
3 (c) Social Security Account No. 212-05-4344

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	divorced

6 (b) Name of husband or wife Mary A. Lloyd
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 25, 1892

8. AGE: Years	Months	Days	If less than one day
54	10	6	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Pipe Fitter (retired)
11. Industry or business Gas & Electric Co.

FATHER
12. Name John T. Lloyd
13. Birthplace Md.

MOTHER
14. Maiden Name Sophie Horn
15. Birthplace Md.

16 (a) Informant Mr. John J. Lloyd
(b) Address 1516 N. Fulton Ave. 17

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/4/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) AUG 1 1947 (Date received by registrar) (b) Huntington Williams, M.D. (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31, 1947, at 11:30a M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/27/ 1947 to 7/31 1947 and that I last saw him alive on 7/27/ 1947

Immediate cause of death	Duration
Myocardial Failure	
Due to Chronic Bronchial Asthma	7 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. W. Saunders
Address 562 Lexington Bldg. Date signed 8/1/47

C53946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered C58946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 325 N. Payson St
(c) Hospital or institution: [illegible]
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 325 N. Payson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jesse M. Lee

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Bertha L.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 1st 1888
8. AGE: Years 59 | Months 3 | Days 29 | If less than one day hr. min.
9. Birthplace Montgomery Co. Md
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Self Employed

FATHER
12. Name Unknown
13. Birthplace Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace Maryland

16 (a) Informant Mrs Bertha L. Lee
(b) Address 325 N. Payson St
17 (a) Burial (b) Date thereof 8/2/37
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Frederick Ave
18 (a) Funeral director John J. Cowan Inc.
(b) Address 901-03 Hollins St.
19 (a) Rec'd by reg. 1947 Huntington Hillsville, Miss

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30th 1937, at 10:30 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1937 to July 30 1937 and that I last saw him alive on July 30 1937

Immediate cause of death: Coronary Thrombosis — Duration
Due to: Arteriosclerotic CVD
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [illegible]
Address 325 Frederick Ave Date signed 8/1/37

V S 150

X

G53947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G53947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1003 W. Lombard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1003 W. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maria Mc Intyre

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9th 1855

8. AGE: Years 92 | Months | Days 21 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md.
(Town, county and state)

10. Usual Occupation House Work

11. Industry or business at home

FATHER
12. Name Patrick Mc Intyre
13. Birthplace Ireland

MOTHER
14. Maiden Name Maria Kelly
15. Birthplace Ireland

16 (a) Informant Mr William Kelly
(b) Address 1003 W. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/2/47 (month) (day) (year)
(c) Cemetery or crematory Sav Cathedral Cem.
Location 4300 Old Frederick Rd

18 (a) Funeral director John J. Gannon Son
(b) Address 901 & 903 Hollins St.

19 (a) Filed by registrar AUG 1 1947 Torrington Nebraska, Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30th 1947, at 1.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 6 1946 to July 30 1947 and that I last saw her alive on July 29 1947.

Immediate cause of death	Duration
Congestive Heart Failure	3 hrs.
Due to Myocardial Heart Disease	20 yrs.
Due to Cachexia	6 mos.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1933 Eutaw St Date signed 8/1/47

X

G53948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (163)

G53948 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 938 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles PRICE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School AUG 1 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) AUG 1 1947 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1947, at 1 45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Mercury poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7/5/47 at M.
(b) Where did injury occur? Private Home
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Ingestion of bichloride tablets

23. Signature George L. Merrill M.D. (Medical Examiner.)
Date signed 7/18/47

G53949 BC# B-84778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

G53949 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard, Green Sts
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1dy
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 602 Vine St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES McDONALD JR.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28 1947

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name JAMES McDONALD
13. Birthplace North Carolina

MOTHER
14. Maiden Name Lucille Hall
15. Birthplace Md.

16 (a) Informant James McDonald
(b) Address 602 Vine St

17 (a) Burial (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School AUG 1 1947

18 (a) Funeral director Commissioner of Health
(b) Address
(c) AUG 1 1947 Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1947, at 2 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 28 1947, to July 29 1947, and that I last saw him alive on July 29 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Congenital Atelectasis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: atelectasis of both lungs

of autopsy: as exp left apex

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jos Shear

Address Univ Hosp. Date signed 8/1/47

X

G53950

BALTIMORE CITY HEALTH DEPARTMENT

OC# G-83422 CERTIFICATE OF DEATH √159

G53950
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cost of age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 26-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1211 Farley Way (If rural give location)
Fraley
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Demmy

3 (b) If veteran, name war — (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/6/47

8. AGE: Years	Months	Days	If less than one day
		25	hr. min.

9. Birthplace University Hospital (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Nicholas Demmy
13. Birthplace Tyndora, Pa.

MOTHER
14. Maiden Name Alean Elizabeth Wells
15. Birthplace Durant, Okla.

16 (a) Informant Father
(b) Address Same as above

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School AUG 1 1947

18 (a) Funeral director Commissioner of Health
(b) Address
AUG 1 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1947, at 8:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1947, to July 31 1947, and that I last saw him alive on July 31 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Congenital atelectasis	
Due to Prematurity.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. L. Long, Jr. M. D.
Address University Hospital Date signed 7-31-47

VS 150

G53951 Bl#B84522 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 159 Registered No. G53951

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 6- JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town ~~259~~ Balto. Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 259 Dallas St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Fitzwater

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-26-47

8. AGE: Years | Months | Days: 2 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or Business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name Gertude Fitzwater
15. Birthplace ?

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Lo[illegible] Johns Hopkins Medical School AUG 1 1947

18 (a) Funeral director
(b) Address Commissioner of Health

19 AUG 1 1947 [illegible] Baltimore, Md.
(Date rec'd by Registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-28-1947, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-26-1947 to 7-28-1947 and that I last saw her alive on 7-28-1947

Immediate cause of death: Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. M. Edmonds M. D.
Address Johns Hopkins Date signed 7-30-47

X

653952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

653952 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Annapolis
(If outside city or town limits, write RURAL and give town)
(d) Street No. 62 Washington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Brown.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-25-47.

8. AGE: Years	Months	Days	If less than one day
			7½ hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Albert Brown
13. Birthplace Md

MOTHER
14. Maiden Name Alice Sedwick
15. Birthplace Md

16 (a) Informant Friends
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School AUG 1 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 AUG 1 1947 Date rec'd by Local Registrar Clayton Williams, M.D.

VS- 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH July 26 1947, at 2:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 25 1947, to July 26 1947, and that I last saw him alive on July 25 1947.

Immediate cause of death	Duration
(a) CARDIO-RESPIRATORY FAILURE	
Due to PREMATURITY	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William A. Spencer M. D.
Address Johns Hopkins Hosp. Date signed 7/26/47

X

G53953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G53953 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2431 W. Lanvale st.
(c) Hospital or institution:
16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2431 W. Lanvale st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM SMITH ROOSE

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife single
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23. 1863

8. AGE: Years	Months	Days	If less than one day
83	7	8	hr. min.

9. Birthplace Washington, D. C.
(Town, county, and state)
10. Usual Occupation retired Physician
11. Industry or business

FATHER
12. Name Wm. L. Roose
13. Birthplace Md

MOTHER
14. Maiden Name Jane Stephenson
15. Birthplace Md

16 (a) Informant Mr. Ross D. Sheppard
(b) Address 2117 Sun Briar Ave Balto 7

17 (a) burial (b) Date thereof Aug 2/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Glenwood Cemetery
Location Washington, D.C.

18 (a) Funeral director John D. Mitchell Sons
(b) Address 1906 Eutaw Place

19 (a) AUG 1 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31, 1947, at 4:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardio-vascular disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 8/1/47

VS 191

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The ect age is especially important. Physicians: please write the causes of death clearly and legibly.

G53954

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G53954 Registered No. 13B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address HARFORD ROAD & HERRING RUN
(c) Hospital or institution:
SYDENHAM HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 min
(e) Length of stay in Baltimore (yrs., mos., or days) 25 min

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County ANNE ARUNDEL
(c) City or town MAYO
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DARLEEN MARIE SELLMAN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3 MARCH 1947

8. AGE: Years	Months	Days	If less than one day
	4	28	hr. min.

9. Birthplace MAYO, Anne Arundel, Md.
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name ROBERT SELLMAN
13. Birthplace MARYLAND

MOTHER
14. Maiden Name MABEL STEWARD
15. Birthplace MARYLAND

16 (a) Informant MABEL SMITH (MOTHER)
(b) Address MAYO, MARYLAND

17 (a) Burial (b) Date thereof Aug 2 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mayo
Location Mayo Md.

18 (a) Funeral director T. A. Hardesty & Son
(b) Address Pasadena, Md.

AUG 1 1947 Thurlington Williams M.D.
(Date rec'd by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1947 at 10 55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 31 1947 to July 31 1947, and that I last saw h[illegible] alive on July 31 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Bronchopneumonia bilateral	
Due to Pertussis	2 WEEKS
Other Conditions Miliary tuberculosis and tuberculous pneumonia	over

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address [illegible] Date signed Aug 1 1947

G53955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G53955

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1535 N. Milton Ave
(c) Hospital or institution: 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 1535 N. Milton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman H. Krug Sr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 211-01-3393

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary Krug

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Mar 30, 1873

8. AGE: Years 74 | Months 4 | Days — | If less than one day ... hr. ... min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Shirt Cutter

11. Industry or business Balto News Post

FATHER
12. Name Friedrich Krug
13. Birthplace Germany.

MOTHER
14. Maiden Name Margaret Gnädesmer
15. Birthplace Germany.

16 (a) Informant Mrs. Mary Krug
(b) Address 1535 N. Milton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 2, 1947 (month) (day) (year)

(c) Cemetery or crematory Balto Cem.
Location North Ave

18 (a) Funeral director L. HEEMANN & SON
(b) Address 56 S. ~~BROADWAY~~ HARFORD Rd.

19 (a) ... (Date received by registrar) (b) ... Registrar

Aug 1 1947

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30, 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1947 to July 30 1947, and that I last saw h— alive on July 29 1947.

Immediate cause of death	Duration
Coronary Occlusion	1 day
Due to Arterio-Sclerosis	Unknown
Due to Myocardial Degeneration	..
Other Conditions Enlarged Prostate	Unknown
Secondary Anemia	..

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature A. F. Rios

Address 24 S. Broadway Date signed Aug 1/47
M. D.

Form 180

X

G53956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G53956
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 425 N.Carey St
(c) Hospital or institution: 19

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 425 N.Carey St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH T. MARTIN

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Widowed

6 (b) Name of husband or wife James
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/5/1878

8. AGE: Years	Months	Days	If less than one day
69	0	26	hr. min.

9. Birthplace Galena, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Perry Scott
13. Birthplace Galena, Md.

MOTHER
14. Maiden Name Mary A.Tumer
15. Birthplace Md.

16 (a) Informant Alberta Hall(Daug)
(b) Address 425 N.Carey St

17 (a) Burial (b) Date thereof 8/4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Olivet Cemetery
Location Galena, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N.Carrollton Ave

19 (a) (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

A

20. DATE OF DEATH Aug. 1st 1947, at 9:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1945 to Aug 1 1947, and that I last saw h[illegible] alive on Aug 1 1947.)

Immediate cause of death — Duration

Cardiac Insufficiency — 2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R H Ward M. D.
Address [illegible] Date signed 8/1/47

AUG 1 1947

X

G53957 BC# D85483

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 159

Registered No. G53957

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 5

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1104 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby boy McConnell

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/28/47

8. AGE: Years	Months	Days	If less than one day
		5 4	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business —

FATHER
12. Name James McConnell
13. Birthplace Athens Ga.

MOTHER
14. Maiden Name Grace Kalb
15. Birthplace Md.

16 (a) Informant J. C. McConnell Catonsville Md.
(b) Address 1104 Edmondson Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 2, 1947 (month) (day) (year)
(c) Cemetery or crematory Good Shepherd
Location Rockland, Md.
18 (a) Funeral director Easton Sons
(b) Address 608 Frederick Ave Caton
19 (a) (Date rec'd by Registrar) (b) Registrar Washington Williams MD

AUG 1 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/1 1947, at 4h. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/28 1947 to 8/1 1947 and that I last saw him alive on 8/1 1947

Immediate cause of death Resp. failure — Duration
Due to Atelectasis, pulmonary
Due to
Other Conditions Prematurity - 3lb 5 oz. - appox. 6 months
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy atelectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert J. Gerachon M.D.
Address St. Agnes Hosp Date signed 8/1/47

161a

C53958 Bertus

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C53958

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Gen'l. Hosp. 2 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town # 11
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1948 Annapolis Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Bertus Shearer

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Grace Shearer
6 (c) If alive, give age 2 years

7. Birth date of deceased (mo., day, yr.) Aug 2, 1897

8. AGE: Years	Months	Days	If less than one day
49	11	30	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Section foreman
11. Industry or business West. Md. R.R.

FATHER
12. Name James H Shearer
13. Birthplace Pa

MOTHER
14. Maiden Name Elmira Hentz
15. Birthplace York Co Pa

16 (a) Informant George A Shoemaker
(b) Address 1948 Annapolis Ave
Remarks

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/6/47 (month) (day) (year)
(c) Cemetery or crematory Reformed Lutheran
Location Glenwood Park

18 (a) Funeral director Williams & Son Inc
(b) Address 1217 E Fayette St

19 AUG 2 1947 Huntington Williams, M.D. Registrar
Filed by Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 1 1947 at 8:08 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 26 1947 to Aug 1 1947 and that I last saw h[illegible] alive on Aug 1 1947.

Immediate cause of death	Duration
Cerebral embolus	4d.
Due to Myocardial infarction and auricular fibril.	2W ?
Due to	
Other Conditions Renal infarction.	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Goldstein M. D.
Address WBGH Date signed 8/7/47

G53959

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

Registered No. G53959

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: Elmhurst Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4059 Chesterfield Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country 405 Chesterfield Ave

3 (a) FULL NAME Anna M. Bitzel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Philip P. Bitzel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 29, 1890

8. AGE: Years	Months	Days	If less than one day
56	9	01	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John B. Hunt
13. Birthplace Md.

MOTHER
14. Maiden Name S. Elizabeth Crocket
15. Birthplace Md.

16 (a) Informant Philip P. Bitzel
(b) Address 4059 Chesterfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 2, 1947 (month) (day) (year)
(c) Cemetery or crematory David Ridge
Location Pikesville, Md.

18 (a) Funeral director Roland L. Fisher
(b) Address 2112 Dundalk Ave.

19 AUG 2 1947 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1947, at 11:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1947 to July 1947, and that I last saw him alive on July 30 1947.

	Duration
Immediate cause of death: Cerebral thrombosis	41 days
Due to: Diabetes mellitus	10 yrs.
Due to:	
Other Conditions: Hypertension, coronary sclerosis	2 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George W. Livingston M.D.
Address 3301 N. Charles St. Date signed 8/1/47 M. D.

VS 150

C53960

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C53960

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey St.
(c) Hospital or institution: Good Samaritan Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1410 Block N. Odenal St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country —

3 (a) FULL NAME Hilberne A. Leibold

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 7, 1883

8. AGE: Years 63 | Months 8 | Days 24 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Home — Partially

11. Industry or business Blind

FATHER
12. Name Andrew Leibold
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary E. Scott
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Emma M. Wielpe
(b) Address 1452 Henry St. Balto 30 Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 2, 1947 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location G. B. Co., Maryland

18 (a) Funeral director T. Howard Evans
(b) Address 1400 St. Charles St. Balto 30 Md.

19 (a) AUG 2 1947 (Date rec'd by registrar) (b) Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH Thurs. July 31 1947, at 1:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 19__ to July 30 1947, and that I last saw h alive on July 30 19 47.

Immediate cause of death: Acute Cardiac Failing — Duration 24 hrs.

Due to: Hypertensive heart disease — years

Due to: Arteriosclerosis — years

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles Cummel Smith M. D.
Address 910 W. Lombard St. Date signed Aug 2

V S 150

Tomasello × 1947.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1332

Registered No. G53961

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3926 Foster Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth DeShields (Ruth C. Deshields)

3 (b) If veteran, name war: ---

3 (c) Social Security Account No.: ---

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Richard DeShields

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 22, 1910

8. AGE: Years: 37 | Months: 5 | Days: 9 | If less than one day: hr. min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER
12. Name: Joseph L. Croney
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: Rita Shirey
15. Birthplace: Balto. Md.

16 (a) Informant: Richard Deshields
(b) Address: 3921 Foster Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Aug. 5/47 (month) (day) (year)
(c) Cemetery or crematory: Greenmount Cem.
Location: Balto. Md.

18 (a) Funeral director: Philip Sherwig Sons
(b) Address: 2024 Orleans St.

19 (a) Rec'd by (b) Registrar

AUG 2 1947 Lexington Millicent, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1, 1947, at 12:45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1947 to August 1 1947 and that I last saw her alive on August 1, 1947

Immediate cause of death: Cardiac & Respiratory Failure — Duration

Due to: Pulmonary edema

Due to: Uremia - Renal Insufficiency

Other Conditions: Pyelonephritis - Ureteral Stricture
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. A. Weightsman M. D.
Address University Hospital Date signed 8-1-47

G53962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √112

Registered No. G53962

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month
(e) Length of stay in Baltimore (yrs., mos., or days) 30

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 619 S. Lakewood (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE BARTKOWIAK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Joseph

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Mar. 25/1897

8. AGE: Years 50 | Months 4 | Days 6 | If less than one day ....hr. ....min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Journal

11. Industry or business Canning

FATHER
12. Name Thomas Kobasa
13. Birthplace Poland

MOTHER
14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Joseph Bartkowiak
(b) Address 619 S. Lakewood ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 4/47 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Highlandtown

18 (a) Funeral director Stephen J. Galloway
(b) Address 1008 S. Kenwood Ave

AUG 2 1947 (Date rec'd) (Registrar) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/31/47 19.... at 10:00 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchial Asthma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.... at .... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Devine M.D.
Medical Examiner.
Date signed 8/1/47

G53963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. G53963

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 719-N. Eden st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 719-N- Eden st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Washington Columbus Hoosey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male | 5. Color or race colored | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Elnora Hoosey

6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Feb-14-1878

8. AGE: Years 69 | Months 5 | Days 17 | If less than one day ____ hr. ____ min.

9. Birthplace Anne Arundel Co. Md.
(Town, county and state)

10. Usual Occupation laborer

11. Industry or business

FATHER 12. Name George W. Hoosey

13. Birthplace Anne Arundel Co. Md.

MOTHER 14. Maiden Name Sarah E. Hicks

15. Birthplace Anne Arundel Co. Md.

16 (a) Informant Elnora Hoosey (wife)

(b) Address 719-N Eden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug-4-47 (month) (day) (year)

(c) Cemetery or crematory Union Methodist

Location Mayotty A. A. Co. Md.

18 (a) Funeral director Mrs. Ida Bailey

(b) Address 1127 E. Jefferson st.

AUG 2 1947 (Date rec'd by registrar) Huntington Williams Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH July - 31 1947 at 5:14 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/21 1947 to 7-31 1947, and that I last saw him alive on 7-31 1947

Immediate cause of death: Metastatic carcinoma, cerebrum — Duration: sev. mos.

Due to (primary bronchogenic)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Rayner Browne X

Address 1530 E. Madison St Date signed 8/1/47

VS 150

053964

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

Registered No. 053964

Every item of information should be carefully supplied. Please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1836- E. Chase Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. NOAH FORD

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Ida
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 15, 1884

8. AGE: Years	Months	Days	If less than one day
63	6	16	hr. min.

9. Birthplace N. C.
(Town, county, and state)
10. Usual Occupation Minister
11. Industry or business

FATHER
12. Name William Ford
13. Birthplace N. C.

MOTHER
14. Maiden Name Nancy ?
15. Birthplace N. C.

16 (a) Informant Ida Ford
(b) Address 1836 E. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 4/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location A. A. County Md.

18 (a) Funeral director Mrs Lott & Edwards
(b) Address 1129 N. Caroline St.

19 (Date received by registrar) AUG 2 1947 Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1, 1947, at 8.30 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Intracranial hemorrhage (sub-dural, subarachnoid, and intracerebral)
Due to:

Other Conditions Hypertrophy of heart
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-28-47 7.45 p. M.
(b) Where did injury occur? Gay St. Baltimore, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Altercation, after auto collision

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 8-1-47

VS 181

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53965

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12/a

Registered No. G53965

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1105 E. Madison St
(c) Hospital or institution: ID
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 E. Madison St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19. 1898

8. AGE: Years 49 | Months 4 | Days 12 | If less than one day hr. min.

9. Birthplace Petersburg Va
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Emmit Johnson
(b) Address 1105 E. Madison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 2 1947
(month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley rd

19 (a) AUG 2 1947 Interment for Williamsport, Md.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1947, at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1947, to July 31 1947, and that I last saw ... alive on July 31 1947.

Immediate cause of death	Duration
Uremia	2 days
Due to Chronic Cardio-renal vascular hypertension	1 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. L. Berry M. D.
Address 1420 E Chase Date signed Aug 2 47

C53966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. C53966

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 117 N. Carey St.
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 117 N. Carey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marguerite J. Weinhold

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife August Weinhold
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 15 1899

8. AGE: Years	Months	Days	If less than one day
48	6	17	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Muller
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Laura V. Cannon
15. Birthplace Baltimore Md.

16 (a) Informant August Weinhold Husband
(b) Address 130 E Clarkson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 2 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1436 Light St.

19 AUG 2 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 1, 1947, at 4 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/21/1946 to 8/1/47 19, and that I last saw her alive on 7/26/ 1947

Immediate cause of death: Coronary thrombosis — Duration: 10 mos.
Due to
Due to
Other Conditions: Hypertensive cardio vascular disease. — Duration: ?
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Deibel
Address 1226 Hanover St. Date signed M. D. 8/2/47

VS 150

X

C53967

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. C53967

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 North Caroline St.
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 901 E. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carmela Piccione

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/6/84

8. AGE: Years 62 | Months 11 | Days 25 | If less than one day ..... hr. ..... min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Antonio Di Noto
13. Birthplace Italy

MOTHER
14. Maiden Name Rose Di Noto
15. Birthplace Italy

16 (a) Informant Rose D'Acre Daughter
(b) Address 318 Spring Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 4/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Arnold Bellohouse
(b) Address 52 N. Morley St.

19 (a) AUG 2 1947 Huntington Williams, M.D. Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 August 1947, at 11 55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 22 July 1947, to 1 Aug 1947, and that I last saw her alive on 1 Aug 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to Arteriosclerotic heart disease	
Due to	
Other Conditions Generalized arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Mary A Porter
Address St. Joseph's Hosp. Date signed 8/1/47 M. D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C53968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

Registered No. C53968

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Provident Hosp. 418
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mo.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1113 W. Franklin Street (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME WARD, PLUMMER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1/19/19

8. AGE: Years 28 | Months 5 | Days 12 | If less than one day ..... hr. ..... min.

9. Birthplace Windsor N. C. (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER 12. Name Plummer Ward Sr

13. Birthplace Windsor, N. C.

MOTHER 14. Maiden Name Minnie Overton

15. Birthplace Windsor N. C.

16 (a) Informant Olney Holley

(b) Address 1309 Baker St

17 (a) Burial (b) Date thereof 8/2/47 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Newberne

Location Newberne, N. C.

18 (a) Funeral director Geo. W. Nelson

(b) Address 1303 Pressman St.

19 (a) AUG 2 1947 Huntington Williams M.D. (Filed by registrar) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31, 1947 at 12 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fractured skull Intracranial hemorrhage

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 7-31-47 at 6 A.M.

(b) Where did injury occur? 1336 Mount st.

(c) Did injury occur at home, on farm, industrial place, in public place? Tavern While at work? No

(d) Means of injury Struck on head with bottle

23. Signature George L. Merrill M.D. Medical Examiner.

Date signed 7/31/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53969

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G53969

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division ST
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 230 N. Carey St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Gaston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Negro	Married

6 (b) Name of husband or wife Annie Gaston
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/25/1888

8. AGE: Years	Months	Days	If less than one day
59	2	6	hr. min.

9. Birthplace Hickory N. Carolina (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business

FATHER
12. Name Not None
13. Birthplace " "

MOTHER
14. Maiden Name Emma Irwin
15. Birthplace NC

16 (a) Informant Mr Carrie Gaston wife
(b) Address 230 n carey st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 4th 42

(c) Cemetery or crematory Hickory NC
Location Hickory NC

18 (a) Funeral director Hickory Funeral Home
(b) Address Hickory N.C.

AUG 2 1942 (Date rec'd by registrar) Registrar

1006 Brantley St

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 31 1942 at 3 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/31/1942 to 7/31 1942, and that I last saw HIM alive on 7/31 1942.

Immediate cause of death Subarachnoid
Due to Hemorrhage
Due to Hypertension
Other Conditions
(Include pregnancy within 3 months of death)

Duration 6 hrs

Date of operation
Major findings of operation:
of autopsy?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William Garner
Address 1514 Division ST Date signed 8/1/42 M.D.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46a

G53970 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Dorchester
(c) City or town Hurlock.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Doris Matthew.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-7-90

8. AGE: Years 57. | Months - | Days 26 | If less than one day ..... hr. ..... min.

9. Birthplace Colorado.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Matthew
13. Birthplace Scotland

MOTHER
14. Maiden Name Alice J Alexander
15. Birthplace Scotland

16 (a) Informant Owner.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof aug 5 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location East New Market

18 (a) Funeral director H B Wilbourn & Son
(b) Address Hurlock

19 (a) 1947 Washington Williams, M.D.
(Date received by registrar) Registrar

AUG 5

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 2 1947, at 2.05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July. 15 1947, to Aug - 2 1947, and that I last saw her alive on Aug - 2 1947.

Immediate cause of death: Carcinoma of Esophagus — Duration: 4/mo.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 7/21/47
Major findings of operation: Ca Esophagus.
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry E. Bahrenburg M. D.
Address J.H.H. Date signed

X

G53971 BALTIMORE CITY HEALTH DEPARTMENT G53971 Registered No.

CERTIFICATE OF DEATH 1243

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 156 N. East Ave.
(c) Hospital or institution: 6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 156 N. East Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MICHAEL F. WIECZYNSKI

3 (b) If veteran, name war ------

3 (c) Social Security Account No. 213-05-5328

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margaret Wieczynski
6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) July 21 1909.

8. AGE: Years	Months	Days	If less than one day
38	0	10	____hr. ____min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Tavern Owner.
11. Industry or business

FATHER
12. Name Felix Wieczynski
13. Birthplace Poland

MOTHER
14. Maiden Name Mollie Cieslak
15. Birthplace Balto., Md.

16 (a) Informant Margaret Wieczynski (Wife)
(b) Address 156 N. East Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/4/47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location German Hill Rd. Balto., Md.

18 (a) Funeral director Charles S. Zeiler
(b) Address 3605 Fait Ave.

19 (a) AUG 3 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

GVS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1947, at 5:25 A.M.

21. I certify that death occurred on the date above stated that I attended deceased from 7/15 1947, to 7/31 1947, and that I last saw h/4 alive on 7/30 1947

Immediate cause of death	Duration
(a) Cyrosis of Liver	6 mo.
(b) Hemorrhages	
Due to (c) Ch. Alky. Cardiosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Theodore F. Lucchesi M. D.
Address 1016 S. East Ave. Date signed 8/1/47

X

G53972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G53972

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1203 E. 35th St.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 4 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 1203 E. 35th St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ann Davis Jenkins

3 (b) If veteran, name war ---
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or ~~wife~~ Benjamin D. Jenkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 29, 1882

8. AGE: Years 65 | Months 6 | Days 4 | If less than one day hr. min.

9. Birthplace Scranton, Pa.
(Town, county, and state)
10. Usual Occupation House-wife
11. Industry or business

FATHER
12. Name Edward E. Davies
13. Birthplace Wales

MOTHER
14. Maiden Name Tabitha Price
15. Birthplace Wales

16 (a) Informant Mr. Benjamin D. Jenkins
(b) Address 1203 E. 35th St.,

17 (a) Burial (b) Date thereof 8-5-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Scranton, Pa.

18 (a) Funeral director George L. Beyer, Jr.,
(b) Address 1512 Hollins St.,

19 (a) [illegible] 1947 (b) Huntington Williams, M.D.
(Date rec'd) (Signature of registrar)

OVS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2, 1947, at 8.45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/24 1945 to Aug 2 1947 and that I last saw h~~er~~ alive on July 1 1947.

Immediate cause of death: Arterio sclerosis Coronary Thrombosis
Due to: Complete Heart Block
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: 18 mos. 18 mos.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. E. Jones M.D.
Address 2818 Pa Ave Date signed 8-6-47

G53973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G53973
Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 minutes
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2828 W Garrison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Katie R. Hermanson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Late Samuel H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
65 64			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Abraham Norinsky
13. Birthplace Russia

MOTHER
14. Maiden Name Unkown
15. Birthplace Russia

16 (a) Informant A. Jesse Hermanson
(b) Address 3417 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 3, 1947 (month) (day) (year)
(c) Cemetery or crematory Sharrei Tfiloh Cemetery
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (Date rec'd by registrar) (b) Huntington Willia[illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 Aug 1947, at 2:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 Aug 1947 to 1 Aug 1947 and that I last saw her alive on 1 Aug 1947.

Immediate cause of death Shock — Duration

Due to Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph L. Matalon, M. D.
Address Date signed 1 Aug 47

VS Form 1947

MIC 3

G53974

BALTIMORE CITY HEALTH DEPARTMENT ✓ G53974
CERTIFICATE OF DEATH 46E Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2133 E. Preston Street
(c) Hospital or institution: 8th
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2133 E. Preston Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Virginia Manko

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-09-5891

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Benjamin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24, 1881

8. AGE: Years 66 | Months 5 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Footer's Cleaners & Dyers

FATHER
12. Name Andrew J. Berger
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary Reymon
15. Birthplace York, Pennsylvania

16 (a) Informant Mrs. Margaret V. Offley
(b) Address 2133 E. Preston Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/4/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (1947 Filed) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31, 1947, at 9:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 31 1947 to July 31 1947, and that I last saw h[er] alive on June 31 1947.

Immediate cause of death	Duration
Lobar pneumonia	4 mo.
Due to Coronary Occlusion	6 mo.
Due to Arteriosclerosis	6 mo.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature S F A Stevens M. D.
Address 2828 Hartford Rd Date signed 8-2-47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53975 — BALTIMORE CITY HEALTH DEPARTMENT — G53975

CERTIFICATE OF DEATH

131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 120 Albemarle (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Evelyn Butaker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Clarke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-16-09

8. AGE: Years	Months	Days	If less than one day
37	8	15	hr. min.

9. Birthplace Washington DC (Town, county, and state)

10. Usual Occupation House work

11. Industry or business

MOTHER / FATHER

12. Name John A Shillman

13. Birthplace Indiana

14. Maiden Name Mary A Getzy

15. Birthplace Spokane Wash

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/6/47 (month) (day) (year)

(c) Cemetery or crematory Bethany

Location Baltimore Md

18 (a) Funeral director Shilhorn & Son Inc

(b) Address 219 S Paca St

19 1947 AUG 8 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1 1947 at 1:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 28 1947 to Aug 1 1947 and that I last saw h.e.r. alive on Aug 1 1947.

Immediate cause of death	Duration
Uremia	
Due to Nephrosclerosis	
Due to Hypertension	
Other Conditions Hypertensive Retinitis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sherman M. Mellinkoff M.D.

Address Johns Hopkins Hosp Date signed Aug 7 47

VS 150

Huntington Williams, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53976 ✓ G53976

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 313 S. Bentalou St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 313 S. Bentalou St. (If outside city or town limits, write RURAL and give town)
(d) ~~Street No.~~ Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country No

3. (a) FULL NAME John F. List

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Heinicke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1871

8. AGE: Years	Months	Days	If less than one day
75 71	9	25	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Butcher

11. Industry or business

FATHER
12. Name Lewis A.
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Zellers
15. Birthplace Germany

16 (a) Informant Lewis A. List
(b) Address 637 Fredrick Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-4-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director George A. Farley
(b) Address Fulton Ave & Fayette St.

19 (a) Date rec'd by registrar AUG 3 1947 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1947, at 9 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 28 1947, to July 31 1947, and that I last saw him alive on July 31 1947.

Immediate cause of death: Pulmonary Edema — Duration

Due to Myocarditis

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert C. Nitsch M. D.
Address 2151 W. Lafayette Ave Date signed 7/31/47

X

G53977 ✓ G53977

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5013 Frederick Ave
(c) Hospital or institution: ***
(d) Length of stay in hospital or inst. (yrs., mos., or days) **
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5013 Frederick Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Julia Lepper

3 (b) If veteran, name war *****
3 (c) Social Security Account No. *****

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	**** Widow

6 (b) Name of husband or wife Charles F Lepper
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7 1874

8. AGE: Years	Months	Days	If less than one day
73	4	24	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation At home
11. Industry or business ***

FATHER
12. Name Louis Rebbel
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Eatrup
15. Birthplace Germany

16 (a) Informant Mrs Lloyd Frech (Daughter)
(b) Address 5013 Frederick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/4/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location North Ave Baltimore Md.

18 (a) Funeral director J Melville Jenkins.
(b) Address 2713 Kirk Ave

19 (a) Date received AUG 3 1947 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/1/47, at 6A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/25/47, to 8/1/47, and that I last saw h[illegible] alive on 7/31/47

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Myocardial Disease	
Due to Cachexia	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Allen Lentz, Jr. M.D.
Address 1433 W. Balto. St Date signed 8/4/47

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53978

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

G53978 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital 815
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 MO.
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1839 N. Caroline St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Anna K Parlett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Daniel H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 7-1871

8. AGE: Years 76 | Months 6 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Adam Eigner

13. Birthplace Germany

MOTHER 14. Maiden Name Lyoan Dantz

15. Birthplace Near Freedom Pa.

16 (a) Informant Elizabeth Moslin

(b) Address 4307 Groveland Ave.

17 (a) Burial (b) Date thereof Aug 4-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Greenmount

Location E. Oak. Av.

18 (a) Funeral director John A. Moran

(b) Address 4 to 8 Greenmount Av.

19 (a) AUG 3 1947 (b) Huntington Williams M.D.
(Rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-1 1947 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-1 1947 to 8-1 1947, and that I last saw her alive on 8-1 1947

Immediate cause of death Circulatory collapse — Duration

Due to Cerebral vascular accident

Due to Arteriosclerotic C V D.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E May M. D.

Address St Joseph's Hosp Date signed 8-1-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G53978

BALTIMORE CITY HEALTH DEPARTMENT ✓ G53978

CERTIFICATE OF DEATH 47B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 24
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 923 Hewitt Way.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Carroll

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-13-91

8. AGE: Years	Months	Days	If less than one day
56.	5	17	hr. min.

9. Birthplace Pa.
(Town, county, and state)
10. Usual Occupation none.
11. Industry or business

FATHER
12. Name William Carey.
13. Birthplace Pa.

MOTHER
14. Maiden Name Margaret Strein
15. Birthplace Switzerland

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof Aug 3, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Forest Lawn Cem.
Location Taylor Pa

18 (a) Funeral director Millirich Funeral Home
(b) Address 2008 Orleans St

19 (a) AUG 3 1947 (b) Huntington Williams, Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 2 1947, at 5.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from July - 8 1947, to Aug - 2 1947, and that I last saw h[illegible] alive on Aug - 2 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Obstruction of trachea	
Due to Carcinomatosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sherman M. Millinkoff M. D.
Address Johns Hopkins Hospital Date signed Aug 2, 1947

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53980

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

G53980

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4728 DARTFORD AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 4728 DARTFORD AVE. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME MERLE J. RHOADS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: TOMMY M. RHOADS

6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1913

8. AGE: Years 34 | Months 6 | Days 7 | If less than one day: hr. min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name CLYDE MARTENY
13. Birthplace West Virginia

MOTHER
14. Maiden Name ALTA DAY
15. Birthplace West Virginia

16 (a) Informant TOMMY M. RHOADS
(b) Address 4728 DARTFORD AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 4 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Lenard S. MacNabb
(b) Address 301 Frederick Ave. Catonsville

AUG 4 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 2 1947, at 12:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 1947, to Aug 2 1947, and that I last saw her alive on Aug 1 1947.

Immediate cause of death: Chronic Nephritis — Duration

Due to

Due to

Other Conditions: Hypertension Uremia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Huntington Williams, M.D.
Address 3325 Frederick Ave. Date signed 8/2/47

G53981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 122 B

Registered No. G53981

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31da
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ~~Baltimore~~ Harford
(c) City or town Rising Sun
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ETTA J. WHITE

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	MARRIED.

6 (b) Name of husband or wife HENRY S. WHITE
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) 9/21/1877

8. AGE: Years	Months	Days	If less than one day
69	10	12	..... hr. ..... min.

9. Birthplace MARYLAND.
(Town, county, and state)
10. Usual Occupation HOUSE WIFE.
11. Industry or business

FATHER
12. Name SAMUEL MORRISON
13. Birthplace Maryland.

MOTHER
14. Maiden Name Elizabeth Holden
15. Birthplace Maryland.

16 (a) Informant Son Samuel M White
(b) Address Rising Sun, Md.

17 (a) Burial (b) Date thereof Aug 7 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~crematory~~ Brookside
Location Rising Sun Md.

18 (a) Funeral director J. E. Tyson
(b) Address Rising Sun Md.

19 (a) ..... (b) Huntington Williams, Md.
...e rec'd by ...

AUG 4 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3 1947, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 3 1947 to Aug 3 1947 and that I last saw ~~her~~ alive on Aug 3 1947

Immediate cause of death	Duration
Coronary Occlusion	2da
Due to Arteriosclerotic - Hypertensive C.V.D.	—
Due to	
Other Conditions Intestinal Obstruction	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Adhesions causing intestinal obstruction

of autopsy: Coronary sclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman R. Freeman Jr. M. D.
Address Union Memorial Hosp. Date signed Aug 3, 47

X

G53982

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V107

Registered No. G53982

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1638 Hazel St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1638 Hazel St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vaclav Losenicky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Zofie Losenicky
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 27 1859

8. AGE: Years	Months	Days	If less than one day
87	11	4 6	hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

MOTHER / FATHER
12. Name Unknown Losenicky
13. Birthplace Czechoslovakia
14. Maiden Name Unknown Unknown
15. Birthplace Unknown

16 (a) Informant Agnes Lauer
(b) Address 1638 Hazel St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-5-47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Ritchie Highway

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul St.

19 AUG 4 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 2, 1947, at 6:40 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1, 1947 to Aug 2, 1947 and that I last saw h/ alive on Aug 2, 1947.

Immediate cause of death	Duration
Broncho-pneumonia	2
Due to	
Due to	
Other Conditions Arterio-sclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A Ehrlich M.D.
Address 730 W. Balto St. Date signed 8/3/47

G53983 Buel

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √56a

G53983 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland Gen. Hosp.
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3114 Chestnut ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Lillian M. Buel

3 (b) If veteran, name war	3 (c) Social Security Account No. 217-01-1804

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Wh	Married

6 (b) Name of husband or wife: William M. Buel Jr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5 Nov. 1902

8. AGE: Years	Months	Days	If less than one day
44	8	27	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Telephone Operator
11. Industry or business Western Union

FATHER
12. Name Charles A. Schroeder
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Caroline Schaumloffel
15. Birthplace Balto. Md.

16 (a) Informant William M. Buel Jr
(b) Address 3114 Chestnut Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/6/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location " Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 AUG 4 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 Aug 1947, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 31 July 1947, to 2 Aug 1947, and that I last saw h.CR. alive on 2 Aug 1947

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Hypertension Cardio vascular disease

Due to

Other Conditions Fibroid

(Include pregnancy within 3 months of death)

Date of operation 1 Aug 1947

Major findings of operation: Fibroid uterus, cystic ovary left

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. T. Morgan M. D.
Address md. Gen. Hosp. Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G53984 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St
(c) Hospital or institution: Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1327 Mt Royal Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Norman E Eberman (EBERMAN)

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-0660

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Mrs Helen Eberman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-26-1887

8. AGE: Years 60 | Months 5 | Days 7 | If less than one day hr. min.

9. Birthplace Indiana (Town, county and state)

10. Usual Occupation Telephone Dept Assistant

11. Industry or business Telephone Co

FATHER 12. Name (Unknown) Eberman

13. Birthplace "

MOTHER 14. Maiden Name Rosa L. Lee

15. Birthplace "

16 (a) Informant Helen M. Eberman

(b) Address 1327 Mt. Royal Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/6/47 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Balto. Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St

19 (Date received by registrar) AUG 4 1947 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3 1947 at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1 1947 to 8-3 1947 and that I last saw him alive on 8-3 1947

Immediate cause of death	Duration
Pulmonary edema	
Due to Congestive Heart Failure	
Due to Chronic hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G.W. Fisher, M.D.

Address Bon Secours Hosp Date signed 8-5-47

VS 150

G.W. FISHER, M.D. X

MARGIN RESERVED FOR BINDING - PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G53985

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3011 Chesterfield Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3011 Chesterfield Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH LEPKA

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or ~~wife~~ Martin J. Lepka
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 28, 1883

8. AGE: Years	Months	Days	If less than one day
63	11	4	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Paul Vacek
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Mary (unknown)
15. Birthplace Czechoslovakia

16 (a) Informant Mrs. Mary Paul - daughter
(b) Address 3011 Chesterfield Avenue

17 (a) Burial (b) Date thereof 8/5/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Holy Redeemer
Location 4033 Belair Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 AUG 4 1947 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1947, at 6:58 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to Aug. 1947 and that I last saw her alive on July 31 1947.

Immediate cause of death	Duration
Cerebral Accident	
Due to Hypertension	
Due to Arteriosclerosis	
Other Conditions Antemortem	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard A. Scitz, M.D.
Address 1701 N. Wash. Date signed 7/2/47

VS 150

LANIUS

G53986

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. G53986

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2401 Aisquith Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Paul Lanius Clough

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Irene Kludy
6 (c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.) July 21 1895

8. AGE: Years	Months	Days	If less than one day
52		10	hr. min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual Occupation: Grain Master
11. Industry or business

FATHER
12. Name: Henry Clough
13. Birthplace: Baltimore Md

MOTHER
14. Maiden Name: Carolyn Lanius
15. Birthplace:

16 (a) Informant: Irene Clough
(b) Address: 2401 Aisquith Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 4 1947 (month) (day) (year)
(c) Cemetery or crematory: Baltimore
Location: North Ave

18 (a) Funeral director: Martin W.P. Offutt Sons
(b) Address: Lombard & Ann Sts.

19 (a) Aug 4 1947 Filed by Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1947, at 7:50 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry*
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Bullet wound of heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-31-47 at 7:30 P.M.
(b) Where did injury occur? 2401 Aisquith Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work?
Means of injury: Firearm

23. Signature: Earl [illegible] M.D. Medical Examiner.
Date signed 8-2-47

X

G53987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G53987

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 63 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4116 Evergreen Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry R. Schwerin

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-9110

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Annie E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 14, 1884

8. AGE: Years 63 | Months 6 | Days 18 | If less than one day hr. min.

9. Birthplace Maryland
(State, county, and state)

10. Usual Occupation Bartender

11. Industry or business New Broadway Hotel

FATHER 12. Name George Schwerin
13. Birthplace Germany

MOTHER 14. Maiden Name Lena Frank
15. Birthplace Maryland

16 (a) Informant Henry Schwerin
(b) Address 5604 Hamlet

17 (a) Burial (b) Date thereof 8/4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore

18 (a) Funeral director Leonard J. Leach
(b) Address 5305 Harford Rd

19 AUG 4 1947 (Date rec'd by registrar) Filed by Washington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1 1947 at 9:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 18 1947 to Aug 1 1947 and that I last saw him alive on Aug 1 1947.

Immediate cause of death	Duration
Acute Cardiac Failure	
Due to Arteriosclerotic Heart Disease	
Due to Generalized Arteriosclerosis	
Other Conditions Lobar Pneumonia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William B. Cooper Jr M. D.
Address South Balto Gen Hosp Date signed Aug 4 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C53988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. C52988

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 18 E. Poultney St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 18 E. Poultney St.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Mary E. Reese

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Henry Reese

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 21, 1867

8. AGE: Years	Months	Days	If less than one day
79	8	11	____ hr. ____ min.

9. Birthplace Pikesville Maryland
(Town, county, and state)

10. Usual Occupation at Home

11. Industry or business —

FATHER
12. Name Lorenzo Rochmer
13. Birthplace Germany

MOTHER
14. Maiden Name Amelia Steigler
15. Birthplace Germany

16 (a) Informant Mrs. Gertrude R. Sanders
(b) Address 18 E. Poultney St. (30) Daughter

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 5, 1947 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director A. Howard Evans
(b) Address 1400 N. Charles St

19 (a) Filed by Registrar Aug 4 1947 (b) Registrar Thurlington for Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sat. Aug. 2 1947, at 2:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to Aug 2 1947 and that I last saw h[illegible] alive on Aug 2 1947

Immediate cause of death	Duration
Carcinoma Sigmoid Colon	6 mos
Due to	
Due to	
Other Conditions Hypertension arteriosclerosis (Include pregnancy within 3 months of death)	6 mos

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Isaac Miller Hall M. D.
Address 1411 N. Charles St Date signed Aug 4 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83B

G53989 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1306 Hilliam Street
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) about 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1306 Hilliam Street
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Serem James Muir

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Nora V. Muir (nee Barrett)
6 (c) If alive, give age 69 years
7. Birth date of deceased (mo., day, yr.) Dec. 14, 1871
8. AGE: Years 75 | Months 7 | Days 19 | If less than one day ____ hr. ____ min.
9. Birthplace Somerset Co., Md (Town, county, and state)
10. Usual Occupation at Home
11. Industry or business —

FATHER
12. Name James W^m Muir
13. Birthplace Somerset Co., Md

MOTHER
14. Maiden Name Emma ?
15. Birthplace Somerset Co. Md

16 (a) Informant Mrs. Nora V. Muir
(b) Address 1306 William Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Wed Aug 6, 1947 (month) (day) (year)
(c) Cemetery or crematory Knoppa Chapel Cem.
Location Broomes Is., Col. Co., Md.

18 (a) Funeral director G. Howard Evans
(b) Address 1400 St. Charles St

19 AUG 4 1947 (b) (Date rec'd by registrar) Huntington Williams, Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sun. Aug 3 1947, at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1947, to August 1947, and that I last saw him alive on August 3 1947.

Immediate cause of death Cardiac Failure, edema — Duration 6 days

Due to Arterio-Sclerosis - advanced

Due to Cerebral Hemorrhage

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature C. E. Pugh M.D.
Address 642 Wash Blvd Date signed 8-4-47 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

053990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 053990

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1714 Madison Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Pitts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/14/07

8. AGE: Years 40 | Months 4 | Days 17 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business Domestic

FATHER
12. Name John
13. Birthplace Virginia

MOTHER
14. Maiden Name Ida Boyd
15. Birthplace Virginia

16 (a) Informant Mary Pitts
(b) Address 1714 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/5/47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Balto. Co. Maryland

18 (a) Funeral director William R. Jackson
(b) Address 940 Penna. Ave

19 (a) AUG 4 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1 1947 at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 26 1947 to Aug 1 1947 and that I last saw him alive on Aug 1 1947.

	Duration
Immediate cause of death Pulmonary edema	
Due to Hypertensive Cardiovascular Renal Disease	
Due to with Uremia	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Calvin B Kearns M. D.
Address University Hosp Date signed 8-1-47

653991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No. 653991

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp. 25 E 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wk
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2400 Annapolis Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Pearl Grimes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Arthur

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/28/02

8. AGE: Years 45 | Months 3 | Days 4 | If less than one day hr. min.

9. Birthplace Calvert Co, Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Augustus Brooks
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie ?
15. Birthplace Maryland

16 (a) Informant Arthur Grimes
(b) Address 2400 Annapolis Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/4/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto Maryland

18 (a) Funeral director William A. Jackson
(b) Address 916 Regua, Abe

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.E.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/31 1947, at 11 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions Heart:- hypertrophy & acute dilatation; Gen. Arteriosclerosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mercuris M.D. Medical Examiner.
Date signed 7-31-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G53992

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6701 Park Heights Ave
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Solomon Rothschild

3 (b) If veteran, name war: NO.
3 (c) Social Security Account No.:

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Augusta Rothschild
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1861

8. AGE: Years 86 | Months 2 | Days 23 | If less than one day ____ hr. ____ min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Life Insurance Bus.

11. Industry or business

FATHER — 12. Name Zadoc Rothschild.
13. Birthplace Germany

MOTHER — 14. Maiden Name Violet Nitzberg
15. Birthplace Germany

16 (a) Informant Stafford J Rothschild
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/4/47 (month) (day) (year)
(c) Cemetery or crematory Balto. Hebrew
Location Balto. Md.

18 (a) Funeral director Harris Sonnenschein & Son
(b) Address 902 Eutaw Place

19 AUG 4 1947 Filed by registrar Washington Willis, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2 1947 at 4:27 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 1947 to Aug 2 1947 and that I last saw him alive on Aug 2 1947.

Immediate cause of death	Duration
Acute pulmonary edema	4 days.
Due to Left ventricular heart failure	
Due to Hypertension Arteriosclerotic heart disease	
Other Conditions Bilateral bronchopneumonia.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John A. Dieuden M.D.
Address Union Memorial Hosp Date signed 8-2-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered G53993

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3507 Copley Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3507 Copley Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank B. Milnor

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ethel B. Milnor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1882

8. AGE: Years	Months	Days	If less than one day
64	9	28	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business B & O Railroad

FATHER
12. Name Jos. K. Milnor
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Emma V. Birckard
15. Birthplace Baltimore

16 (a) Informant Mrs. Ethel P. Milnor
(b) Address 3507 Copley Road

17 (a) Burial (b) Date thereof 8/5/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Aves.

AUG 4 1947 (b)
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2, 1947 at 3:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-10 1947 to Aug 2 1947, and that I last saw h[illegible] alive on Aug 1 1947

Immediate cause of death Paralysis — Duration 1 day, 16 Chronic
Due to High Blood Pressure
Due to Hardening
Other Conditions Cancer of Larynx
(Include pregnancy within 3 months of death)

Date of operation X
Major findings of operation: X
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide X
(b) Date of occurrence X at M
(c) Where did injury occur? X
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? X While at work? X
(Specify type of place)
(e) Means of injury X
23. Signature A. O. Pearce
Address 3507 Copley Rd Date signed 8/4/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53994

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 20

G53994 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1221 Roundhill Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 25yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1221 Roundhill Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Justin Russell Kinsey

3 (b) If veteran, name war No

3 (c) Social Security Account No. 212 -01 -3799

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife M. Katherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 14, 1899

8. AGE: Years 47 | Months 7 | Days 18 | If less than one day hr. min.

9. Birthplace Brighton, Mich.
(Town, county, and state)

10. Usual Occupation Ass. Circulation Mgr. (Rural)

11. Industry or business

FATHER
12. Name J. Albert Kinsey
13. Birthplace Canada

MOTHER
14. Maiden Name Ella
15. Birthplace Canada

16 (a) Informant Mrs. Katherine Kinsey
(b) Address 1221 Roundhill Rd.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 8/4/47 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount Ave.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves.

19 (a) AUG 4 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 40

20. DATE OF DEATH 8/2/ 1947, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 1947 to Aug 2 1947 and that I last saw him alive on Aug 2 1947.

Immediate cause of death Renal Tuberculosis — Duration 1 yr 5 mos
Chronic arthritis — 6 yrs
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Leo D. Lafferty M. D.
Address Pathologist Path. Date signed 8/4/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C53995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937 D

Registered No. C58995

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 719 N. Longwood St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 719 N. Longwood St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KATE GRACE HUPFIELD

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Henry Hupfield
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1862

8. AGE: Years	Months	Days	If less than one day
85	5	20	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Sidney Thomas Taylor
13. Birthplace Pocomoke City, Md.

MOTHER
14. Maiden Name Maria Ann Bzxter
15. Birthplace Md.

16 (a) Informant Mr. Fred H. Hupfield, grandson
(b) Address 1702 Windemere Ave.

17 (a) Burial (b) Date thereof 8/4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director W.M. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) AUG 4 1947 (b) Huntington Williams, M.D. Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 1, 1947, at 11:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 30 July 1947 to 1 Aug 1947, and that I last saw her alive on 1 Aug 1947.

Immediate cause of death	Duration
Cerebral embolus	
Due to Auricular fibrillation	? 1 week
Due to Arteriosclerotic heart + vascular disease with myocardial degeneration	Indefinite
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Emil H. Henning Jr M. D.
Address 601 Winans Way Date signed 2 Aug
Balto 29 Md

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1133a

Registered No. G53996

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway St.
(c) Hospital or institution: Church Home & Hospital 15th
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 14
(e) Length of stay in Baltimore (yrs., ~~mos., or days~~) 35 years

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2302 ROSLYN AVE. (If rural give location)
(e) Citizen of foreign country? no (~~Yes or~~ No) If yes, name country

3 (a) FULL NAME MRS. BLANCHE MARIE CLARKE

3 (b) ~~If veteran, name war~~

3 (c) ~~Social Security Account~~ No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: WIDOWED

6 (b) Name of husband or wife: Thomas J. Clarke, Sr.

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 3-31-1876

8. AGE: Years 71 | Months 4 | Days 1 | If less than one day ____ hr. ____ min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name William Burnette
13. Birthplace W. Virginia

MOTHER
14. Maiden Name ~~Ada Whiting Todd~~
15. Birthplace W. Virginia

16 (a) Informant CHARLES B. CLARKE
(b) Address 2302 Roslyn Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/5/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) AUG 4 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 August 1947 at 4:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 18 July 1947 to 1 August 1947, and that I last saw h[illegible] alive on 1 August 1947.

Immediate cause of death PYONEPHROSIS — Duration 2 days

Due to URETERAL STENOSES, BILATERAL — Duration 6 years

Due to ____

Other Conditions ARTERIO SCLEROSIS GENERALIZED

(Include pregnancy within 3 months of death)

Date of operation ____

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? ____
(e) Means of injury ____

Signature D E Fisher M.D.
Address Church Home Hosp. Date signed 8-1-47

VS 150

G53997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 13 B

Registered No. G53997

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2233 Druid Hill Ave
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2233 Druid Hill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** James Lee Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-07-2462

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lottie L. Taylor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1 - 1878

8. AGE: Years 69 | Months 3 | Days 0 | If less than one day hr. min.

9. Birthplace Culpeper Va.
(Town, county, and state)

10. Usual Occupation Porter (retired)

11. Industry or business B. & O. R.R.

FATHER
12. Name James Lee Taylor
13. Birthplace Va.

MOTHER
14. Maiden Name Jennie Taylor
15. Birthplace Va

16 (a) Informant Lottie L. Taylor (wife)
(b) Address 2233 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 5 1947 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md.

18 (a) Funeral director John M. Johnson
(b) Address 1347 Druid Hill Ave

Aug 4 1947
(Date rec'd by registrar)

(b) Thornton Williams
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 1" 1947 at 6A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 25 1946, to Aug 1 1947, and that I last saw h alive on July 31 1947

Immediate cause of death	Duration
Chronic Nephritis	2 years
Due to	
Due to Chr. Myocarditis	1 year
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Calvin B. LeCompte M. D.
Address 1113 N Caroline St Date signed 8/2/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G53998

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1513 h Washington Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1513 h Washington Street (If rural give location)

(e) If foreign born, how long in U. S. A.? 64 years

3 (a) FULL NAME George Pfeifer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Julia Pfeifer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 12, 1872

8. AGE: Years 74 | Months 8 7 | Days 21 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER 12. Name George Pfeifer

13. Birthplace Germany

MOTHER 14. Maiden Name Katherine Bauer

15. Birthplace Germany

16 (a) Informant Mrs. Julia Pfeifer

(b) Address 1513 h Washington Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-6-47 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cemetery

Location North Ave & Rose St

18 (a) Funeral director Albert L. Frith Jr

(b) Address 1645 h Chester St Edgewood Harford Co, Md.

19 AUG 4 1947 (Date rec'd by registrar) (b) Huntington Pettiaux, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1947, at 2 p. m. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 24 1947 to May 2 1947, and that I last saw h alive on May 2 1947.

Immediate cause of death Cardiac Dilatation — Duration 1 day

Due to Chr. Val. Heart Dis: Aortic - Insufficiency

Due to

Other Conditions Broncho-pneumonia — Last June 24/47

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

Signature H. N. Hess M.D.

Address 1520 E 33rd Date signed May 4/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G53999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G53999

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 610 Somerset Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md — (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 610 Somerset Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. Walter G. Boyd

3 (b) If veteran, name war — | 3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Caroline Hall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1. 1866

8. AGE: Years	Months	Days	If less than one day
80	11	1	hr. min.

9. Birthplace Md. Cecil Co.
(Town, county, and state)
10. Usual Occupation Dentist
11. Industry or business

FATHER 12. Name John A. Boyd
13. Birthplace Md

MOTHER 14. Maiden Name Ellen Gillespie
15. Birthplace Md —

16 (a) Informant Caroline H. Boyd
(b) Address 610 Somerset Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 4 1941 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director John O Mitchell Sons
(b) Address 1908 Eutaw Place

19 AUG 4 1941 (c) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 1 1941, at 10:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1 1941 to Aug 1 1941, and that I last saw him alive on Aug 1 1941.

Immediate cause of death	Duration
Coronary occlusion	10 min.
Due to Arteriosclerosis	10 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Holmes Boyd M.D.
Address 24 E. Eager St. Date signed 8/2/42

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Died

G54000 BC# B86174

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 161a

Registered No. G54000

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 17½ hours.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1920 McElderry St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Baby boy HIGGINS (Paul Higgins 3rd)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 2, 1947

8. AGE: Years	Months	Days	If less than one day
			17 hr. 30 min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation.....
11. Industry or business.....

FATHER
12. Name Paul Higgins, M.D.
13. Birthplace New York

MOTHER
14. Maiden Name Elima Kearsley
15. Birthplace Austra lia

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Cremation (b) Date thereof Aug 4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Dr Park
Location 3501 Frederick Ave

18 (a) Funeral director John O Mitchell & Sons
(b) Address 1200 Eutaw Place

19 AUG 4 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3 1947, at 2:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from August 2 1947, to August 3 1947, and that I last saw him alive on August 3 1947.

Immediate cause of death	Duration
Due to Atelectasis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature [signature] M.D.
Address Johns Hopkins Hospital Date signed 8-3-47
M. D.

G54001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G54001

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 Beechdale Rd.
(c) Hospital or institution: ----------
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ----------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 110 Beechdale Rd. (If rural give location)
(e) Citizen of foreign country? ---------- (Yes or No)
If yes, name country ----------

3 (a) FULL NAME Sue M. Martenet

3 (b) If veteran, name war ----------
3 (c) Social Security Account No. ----------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband ##### Howard L. Martenet
6 (c) If alive, give age ---years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1885

8. AGE: Years	Months	Days	If less than one day
62	6	1	---hr. ---min.

9. Birthplace Mathews Co., Va. (Town, county, and state)
10. Usual Occupation None
11. Industry or business ----------

FATHER
12. Name Alexander Marchant
13. Birthplace Virginia

MOTHER
14. Maiden Name Susan F. Forrest
15. Birthplace Virginia

16 (a) Informant Mr. Howard Martinet
(b) Address 110 Beechdale Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/5/47 (month) (day) (year)
(c) Cemetery or crematory ######## Loudon Park
Location Baltimore, Md.

18 (a) Funeral director H. H. Meeks and Son
(b) Address 1347 N. Calvert St.

19 (a) AUG 4 1947 (b) Washington Williamson
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 3rd 1947, at 12:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1946 to Aug 1947 and that I last saw her alive on Aug 2nd 1947.

Immediate cause of death Arteriosclerosis, Cerebral

Duration

Due to ----------

Due to ----------

Other Conditions ----------

(Include pregnancy within 3 months of death)

Date of operation ----------

Major findings of operation: ----------

of autopsy: ----------

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ----------
(b) Date of occurrence ---------- at ---------- M
(c) Where did injury occur? ---------- (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ---------- While at work? ---------- (Specify type of place)
(e) Means of injury ----------

23. Signature William G Kelfeich M. D.
Address 5006 Roland Ave Date signed Aug 4 47

G54002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered No. G54002

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2601 N. Charles St.
(c) Hospital or institution: ---
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ---
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2601 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? --- (Yes or No)
If yes, name country ---

3 (a) FULL NAME Bessie I. Wilkinson

3 (b) If veteran, name war ---
3 (c) Social Security Account No. ---

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife ---
6 (c) If alive, give age ---years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years: About 76 | Months: --- | Days: --- | If less than one day: ---hr. ---min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business ---

FATHER
12. Name Thomas S. Wilkinson
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Fanny Bennett
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Jane Wilkinson
(b) Address 2601 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/6/47 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Green Mount
Location Baltimore, Md.

18 (a) Funeral director H. K. Mears and Son
(b) Address 805 N. Calvert St.

19 (a) AUG 4 1947 (Date rec'd by registrar) (b) Huntington Williams

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 3 1947, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 22 1947, to Aug 3 1947 and that I last saw her alive on Aug 2 1947

	Duration
Immediate cause of death: Cerebral apoplexy	
Due to: Arteriosclerosis	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Lloyd M. D.
Address 701 Cathedral Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G54003

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4515 Park Hgts Ave
(c) Hospital or institution: ----------
(d) Length of stay in hospital or inst. (yrs., mos., or days) -----
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ----------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4515 Park Hgts. Ave.
(If rural give location)
(e) Citizen of foreign country? ---------- (Yes or No)
If yes, name country ----------

3 (a) FULL NAME Leitha A. Sommerfeld

3 (b) If veteran, name war ----------
3 (c) Social Security Account No. ----------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband ~~####~~ Isador Sommerfeld
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) May 9, 1870

8. AGE: Years	Months	Days	If less than one day
77	2	24	--- hr. --- min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business ----------

FATHER
12. Name George Kulms
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden Name Sarah Eckenrode
15. Birthplace Taneytown, Md.

16 (a) Informant Mr. Isador Sommerfeld
(b) Address 4515 Park Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/5/47 (month) (day) (year)
(c) Cemetery ~~########~~ St. Joseph's
Location Taneytown, Md.

18 (a) Funeral director H. H. Mears and Sons
(b) Address 805 N. Calvert St.

19 (a) AUG 4 1947 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3 1947, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1944 to Aug. 3 1947 and that I last saw h~~e~~r alive on Aug. 1 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to Arteriosclerotic heart disease and arteriosclerosis	3 yrs.
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John H. Frasher
Address 1035 N. Calvert Date signed 8/4/47

Huntington Williams, MD

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The certificate is especially important. Physicians: please write the cause of death clearly and legibly.

C54004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1647

Registered No. C54004

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 310 E. 28th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Phillip Ludwig

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 215-05-1452

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mattie J. Ludwig

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Jan 11, 1880

8. AGE: Years 67 | Months 6 | Days 22 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER
12. Name Theodore Ludwig
13. Birthplace Md.

MOTHER
14. Maiden Name Caroline Seibel
15. Birthplace Germany

16 (a) Informant Mattie J. Ludwig
(b) Address 310 E. 28th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 5/47 (month) (day) (year)
(c) Cemetery or crematory Manchester
Location Md.

18 (a) Funeral director Jacob Wink Son.
(b) Address Manchester Md.

19 AUG 4 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/2/47 1947, at 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/21 1947 to 8/2 1947, and that I last saw him alive on 8/2 1947

Immediate cause of death Peritonitis
Pulmonary edema
Left Hemothorax
Due to Trauma

Due to

Other Conditions Transverse Colostomy

(Include pregnancy within 3 months of death)

Date of operation 7/21

Major findings of operation: Lacerated Lung, transverse colon, stomach

of autopsy: Peritonitis, pul. edema

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Probable suicide attempt
(b) Date of occurrence 7/21/47 at M
(c) Where did injury occur? Baltimore (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no
(e) Means of injury Probably knife

23. Signature Marvin Shapiro
Address Sinai Hosp Date signed 8/4/47

Earl L. Rozen, M.D., X

G54005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G54005

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2123 Division St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph (Makell) Mackel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Alease

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17 1914

8. AGE: Years	Months	Days	If less than one day
33	-	15	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Truck Driver

11. Industry or business

FATHER
12. Name Joseph Mackel
13. Birthplace Md.

MOTHER
14. Maiden Name Bertha Houston
15. Birthplace Md.

16 (a) Informant Mrs. Alease Mackel
(b) Address 2123 Division St

17 (a) Burial (b) Date thereof 8-5-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 3227 Edmondson Ave.

19 (a) AUG 4 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1, 1947 at 6 40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute pulmonary tuberculosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl A. Ryan M.D.
Medical Examiner
Date signed 8-1-47

G54006 Mattie Roberts

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

G54006 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1007 W Saratoga St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1007 W Saratoga St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mattie Roberts
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-2-1880

8. AGE: Years 66 67 | Months 11 | Days 29 | If less than one day hr. min.

9. Birthplace Appatomax Co. Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William H. Wright
13. Birthplace Appatomax Co. Va.

MOTHER
14. Maiden Name Sarah M. Patterson
15. Birthplace Appatomax Co. Va

16 (a) Informant Mrs. Mary Southerland
(b) Address 1007 W.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 4 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 AUG 4 1947 (Date rec'd by registrar) (b) Huntington West Virginia

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/31 1947 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/1 1947 to 7/31 1947, and that I last saw her alive on 7/30 1947

Immediate cause of death: Bronchopneumonia Cerebral Hemorrhage — Duration 6 mos

Due to Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. C. Carson

Address 1001 Adaline signed 8/4/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

654007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √93E

Registered No. G54007

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1447 Decatur St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1447 Decatur St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Wladyslaw Walter Simon (Szymon)
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Laura Simon
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 22 1898
8. AGE: Years 49 | Months — | Days 10 | If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Florist
11. Industry or business
FATHER 12. Name John Simon
13. Birthplace Poland
MOTHER 14. Maiden Name Zaczyk
15. Birthplace Poland
16 (a) Informant Laura Simon
(b) Address 1447 Decatur St
17 (a) Buried (burial, cremation, or removal) (b) Date thereof Aug 4 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore
18 (a) Funeral director Fred W Ozazewski
(b) Address 1930 Eastern Ave
19 AUG 4 1947 (Rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/1/47 19 at 9:20 M
21. I certify that death occurred on the date above stated; that I attended deceased from 8/1/47 19 to 8/1/47 19 and that I last saw h[illegible] alive on 8/1/47

Immediate cause of death	Duration
Acute congestive heart failure	2 days
Due to Cardiac Asthma	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Isaac Hillelsohn M. D.
Address 1224 S Clinton St Date signed 8/2/47.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-1124 G54008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

G54008 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9days
(e) Length of stay in Baltimore (yrs., mos., or days) 3yrs. ✓

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 740 N. Lexington st. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Owens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Ella Bell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5- 1927 ?

8. AGE:	Years	Months	Days	If less than one day
	19?	9	28	hr. min.

9. Birthplace S.C.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Frank Owens
13. Birthplace S.C.

MOTHER
14. Maiden Name Mary Brice
15. Birthplace S.C.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 8/6/47 (month) (day) (year)
(c) Cemetery or crematory Manchester
Location Hampstead, Md.

18 (a) Funeral director William T. Jackson
(b) Address 916 Penna. Ave.

19 (a) (Date rec'd by registrar) (b) Registrar
AUG 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION PM

20. DATE OF DEATH Aug. 2 1947, at 8.45M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-23- 1947 to 8-2- 1947, and that I last saw h in alive on 8-2- 1947.

Immediate cause of death	Duration
Laparatomy	
Due to Pulmonary tuberculosis.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Bilat. pulmonary Tb

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wellington H. Vreeland M.D.
Address Balt. City Hosp. Date signed 8 Aug 47

X

G54009

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G54009

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 112 S. Patterson Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William S. Hunt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20, 1882

8. AGE: Years	Months	Days	If less than one day
64	11	15	hr. min.

9. Birthplace Baltimore - Maryland
(Town, county, and state)

10. Usual Occupation Printer

11. Industry or business

FATHER
12. Name George W. Hunt
13. Birthplace Baltimore - Md.

MOTHER
14. Maiden Name Mary L. Watson
15. Birthplace Baltimore - Md.

16 (a) Informant Frances L. Blumer
(b) Address 112 S. Patterson Pk Ave

17 (a) Burial (b) Date thereof 8/7/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mouland Memorial
Location Taylor Avenue

18 (a) Funeral director John E. Gillespie
(b) Address 2415 E. Oliver St.

19 (a) (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

AUG 4 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-4- 1947, at 8:30 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions Generalized Arteriosclerosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner.

Date signed 8-4-47

X

G54010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G54010

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2520 E. Hoffman Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2520 E. Hoffman Street (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Stein

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 213-05-3586

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	divorced

6 (b) Name of husband or wife February 24th, 1916 87

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER
12. Name John Stein
13. Birthplace Germany

MOTHER
14. Maiden Name Marie Feldner
15. Birthplace Germany

16 (a) Informant Frederick P. Stein
(b) Address 1804 N. Lloyd Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-5-47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Eastern Avenue

18 (a) Funeral director Frederick D. Miller, Inc.
(b) Address 3019 E. Monument St. Huntington Hotel Baltimore, Md.

19 (a) AUG 4 1947 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 2 1947, at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1947 to Aug 2 1947. and that I last saw h alive on Aug 2 1947.

Immediate cause of death	Duration
Cerebral Hemmorrhage	12 HRS.
Due to Hypertension C-V Disease	2
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward A. Kallins M. D.
Address 1847 W. North Ave Date signed Aug 4, 1947

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G54011

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1510 Orleans Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1510 Orleans St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Doris Mitchell Holliday

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1910

8. AGE: Years	Months	Days	If less than one day
36	7	6	hr. min.

9. Birthplace Dunn, N. C. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Edward Mitchell
13. Birthplace Wilson N, C.

MOTHER
14. Maiden Name Alice Maynor
15. Birthplace Fayettesville, N. C.

16 (a) Informant Walter A. Maynor
(b) Address 459 Swartz Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 4, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location Brooklyn, Md.

18 (a) Funeral director Elroy C. Wilson
(b) 1000 Brantly Ave. Williamsport, Md.

19 (a) AUG 4 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31st 1947, at 7:30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/30 1946, to 7/31 1947, and that I last saw her alive on 7/30 1947.

Immediate cause of death	Duration
Carcinomatosis primary - cervix.	approx 1 yr.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Rayner Browne M. D.
Address 1500 E. Madison St Date signed 8/2/47

VS 150

Rayner Browne X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G54012

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 112 Market Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES BRANCH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Handy Man

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant Annie Johnson

(b) Address 405 Calvert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 4, 1947 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem.

Location Brooklyn Md

18 (a) Funeral director Elroy O Wilson

(b) Address 1055 Hanover ave Huntingtown Kilmarnock, Va.

19 AUG 4 1947 (b) (Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8, 1947, at 12.45 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ or accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arterioselerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 7-8-47

G54013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓55E

Registered No. G54013

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 819 E. Chase St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1523 N. Carolina St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen B. Hayes

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Howard M. Hayes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1892

8. AGE: Years: 55 | Months: 1 | Days: 23 | If less than one day: 2 hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Home Wife

11. Industry or business

FATHER
12. Name George W. Bishop
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Susan Hagerty
15. Birthplace Baltimore, Md

16 (a) Informant Mr. Charles J. Hayes
(b) Address 1523 N. Carolina St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 5 '47 (month) (day) (year)

(c) Cemetery or crematory Mt. Cathedral Cem.
Location 4300 Old Frederick Rd.

18 (a) Funeral director Edgar W. Conklin & Son
(b) Address 124 E. Eager St.

19 (a) Filed Aug 4 1947 (b) Thurlington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 2, 1947, at 7p M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1943 to Aug 1 1947 and that I last saw h[illegible] alive on Aug 1, 1947

Immediate cause of death
Generalized Malignancy of Lymphoblastoma
Due to Lymphoblastoma of Cervical Glands (Brill-Symmers Disease)
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation Aug 2 '47
Major findings of operation: Lymphoblastoma of Cervical Glands
of autopsy:

about 3 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Daniel Fes. Wilson MD M. D.
Address 319 Med Arts Date signed

G54014

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

Registered No. G54014

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Madison & Linden

(c) Hospital or institution: Maryland Gen. Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1532 Sheffield Rd #18 (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME John ~~Joseph~~ Smith John Joseph Smith

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: M

5. Color or race: Wh

6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~: Married

6 (b) Name of husband or wife: Florence E. Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): August 3, 1947

8. AGE: Years 69 | Months 11 | Days 29 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Mfgr. Agent

11. Industry or business: Self

FATHER

12. Name: John T. Smith

13. Birthplace: ?

MOTHER

14. Maiden Name: Mary ?

15. Birthplace: ?

16 (a) Informant: Mrs. Florence E. Smith

(b) Address: 1532 Sheffield Road 18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug. 5, 1947 (month) (day) (year)

(c) Cemetery or crematory: New Cathedral Cem

Location: Baltimore, Md.

18 (a) Funeral director: Wm. J. Tickner & Sons, Inc.

(b) Address: North & Pennsylvania Aves.

AUG 4 1947 (Date rec'd by Registrar) (b) Thurlington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2 Aug 1947, at 5:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 31 July 1947 to 2 Aug 1947, and that I last saw him alive on 2 Aug 1947

Immediate cause of death	Duration
Undetermined	
Probably a ruptured abdominal aneurysm	
Due to	
Due to	
Other Conditions Bleeding from intestinal tract	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature M. T. McGoogan M. D.

Address Maryland Gen. Hosp. Date signed Aug 2 1947

G54015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G54015 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore Balto.
(c) City or town Govanstown Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5106 Spring Lake Way
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Charles H. Pinkerton, Jr.

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 4-7-37

8. AGE: Years	Months	Days	If less than one day
10	3	25	..... hr. ..... min.

9. Birthplace Baltimore Md
(Town, county and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Charles H. Pinkerton Sr.
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Virginia Gebauer
15. Birthplace Portsmouth Va Gebauer

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Aug. 5, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Pikesville, Md.

18 (a) Funeral director William J. Tickner & Sons, Inc.
(b) Address North & Pa. Aves.

19 AUG 4 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 2 1947, at 6 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 1947 to Aug 2 19 47 and that I last saw him alive on Aug 2 19 47

Immediate cause of death APLASTIC ANEMIA — Duration 4 MO

Due to UNDETERMINED CAUSE

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: —

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature John S. Morris M. D.
Asst Pres. Pediatrician
Address Johns Hopkins Date signed 2 Aug 47

VS 150

G54016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered No. G54016

MARGIN RESERVED. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1404 Battery Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) about 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) ~~City~~ or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1404 Battery Ave.
(If rural, give location)
(e) Citizen of foreign country? No: (Yes or No)
If yes, name country —

3 (a) FULL NAME John Neuhaus

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary Neuhaus (nee Hasenahl)
6 (c) If alive, give age 73 years
7. Birth date of deceased (mo., day, yr.) Nov. 1st 1876
8. AGE: Years 70 | Months 9 | Days 2 | If less than one day ____hr. ____min.
9. Birthplace Germany (Town, county and state)
10. Usual Occupation Retired Baker
11. Industry or business Physically disabled

FATHER
12. Name [redacted] ?
13. Birthplace Germany

MOTHER
14. Maiden Name [redacted] ?
15. Birthplace Germany

16 (a) Informant Mary Neuhaus (Wife)
(b) Address 1404 Battery Ave.

17 (a) Burial (b) Date thereof Aug. 7, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location B. A. Co., Maryland

18 (a) Funeral director A. Howard Evans
(b) Address 1400 L. Charles Street

19 (a) AUG 4 1947 Huntington Williams M.D.
(Date received by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sun. Aug. 3 1947, at 1:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2 1947, to Aug 3 1947 and that I last saw him alive on Aug 3 1947.

	Duration
Immediate cause of death: Cerebral Hemorrhage	3 days
Due to: Hemiplegia	3 days
Due to: Arterial Sclerosis	7 mos
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature C. B. Whittelsey M.D.
Address 1279 Williams St Date signed 8/4/47 M. D.

G54017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 ✓

Registered No. G54017

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 312 PENN ST.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 ✓
(e) Length of stay in Baltimore (yrs., mos., or days) 48

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 312 PENN ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country LITHUANIA.

3 (a) **FULL NAME** FRANK BRIDICKAS - ALSO KNOWN AS (BEDSKY) BEDISTKY

3 (b) If veteran, name war NO. | 3 (c) Social Security Account No. 215-07-4127

4. Sex M. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of ~~husband~~ or wife Jadwiga J. Biedrakas | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-2-1881

8. AGE: Years 66 | Months 6 5 | Days - | If less than one day ... hr. ... min.

9. Birthplace LITHUANIA. (Town, county, and state)

10. Usual Occupation TAILOR

11. Industry or business SILVER, CUTLERY

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Unknown.
15. Birthplace

16 (a) Informant ANNA BRIDIEKAS
(b) Address 312 PENN ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-5-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Chas. W. Kaelin
(b) Address 1947 McHenry St.

AUG 4 (Date rec'd by registrar) Washington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2nd 1947, at 1:A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946, to August 1947, and that I last saw him alive on Aug. 1st 1947

Immediate cause of death Pulmonary edema — Duration

Due to Anasarca — 1-2 yr

Due to Chronic myocarditis

Other Conditions Advanced Arteriosclerosis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address 642 Wash Pl. Date signed 8-4-47. M.D.

VS 150

X

G54018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G54018 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Josephs Hosp
(c) Hospital or institution: Caroline St. & Oliver Sts
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Bal.
(c) City or town Balto City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2743 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Catherine M Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Louis E

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ~~Feb~~ 4-5-77

8. AGE: Years 70 | Months 2 | Days 27 | If less than one day ... hr. ... min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Martin White
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Boyle
15. Birthplace Ireland

16 (a) Informant Louis E Davis
(b) Address 2743 Edmondson Ave

17 (a) Burial (b) Date thereof Aug 6 '47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Catholic
Location Old Frederick Rd

18 (a) Funeral director Harry H Wright
(b) Address 4101 Edmondson Ave

19 AUG 4 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to Aug 4 1947, and that I last saw her alive on Aug 3 1947

Immediate cause of death	Duration
CARDIO RESPIRATORY FAILURE	
Due to CARCINOMA	
LARGE BOWEL	
Due to	
GEN: METASTASIS	
Other Conditions LIVER	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John B. Wells M.D.

Address St Josephs Hosp Date signed Aug 7 1947

G54019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B

Registered No. G54019

MARGIN RESERVED — The information should be carefully supplied. Every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5121 Greenwich Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5121 Greenwich Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry E. Goertz, Sr.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Catherine (B.) U.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1861

8. AGE: Years 86 | Months | Days 4 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Hugo Goertz
13. Birthplace Germany (Pa.)

MOTHER
14. Maiden Name Frederika Shuta
15. Birthplace [illegible]

16 (a) Informant [illegible]
(b) Address [illegible]

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/5/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd

18 (a) Funeral director Henry H. Wittle
(b) Address 4101 Edmondson Ave

AUG 4 1947 (Date rec'd by Registrar) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/2/47 19 , at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to Aug 2 1947 and that I last saw him alive on Aug 1 1947

Immediate cause of death	Duration
Carcinoma of the Stomach	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 3326 Frederick Ave Date signed 8/4/47 M. D.

X

G54020

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No. G54020

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey St.
(c) Hospital or institution: Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1815 W. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances L. Baker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Henry T. Baker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 4. 1906

8. AGE: Years 40 | Months 10 | Days 29 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation H.W.

11. Industry or business

FATHER — 12. Name Peter B. Whisman

13. Birthplace Va.

MOTHER — 14. Maiden Name Rachael Jane Helmick

15. Birthplace Va.

16 (a) Informant Henry T. Baker

(b) Address 1815 W. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 6/47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location 3501 Frederick Rd

18 (a) Funeral director Harry H. Little

(b) Address 4101 Edmondson Ave

AUG 4 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 3. 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1947, to Aug 2 1947, and that I last saw him alive on Aug 2 - 1947.

Immediate cause of death: Carcinomatosis — Duration: years

Due to Uterine Carcinoma — months

Due to

Other Conditions Marasmus —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles Cummerow M.D. M. D.

Address 910 W. Lombard Date signed Aug. 4/47

X

C54021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

140 C

Registered No. C54021

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1534 E. Pratt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Doris Elizabeth Williamson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Alexander
6 (c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.) 1-8-22.

8. AGE: Years	Months	Days	If less than one day
25	6	24	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation House-wife
11. Industry or business

FATHER
12. Name Wm Turpin
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Gardner.
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 5/47 (month) (day) (year)
(c) Cemetery or crematory W. M. Calvary Cem
Location A. A. County, Md

18 (a) Funeral director Mrs Lott A. Elliott & Dept
(b) Address 1129 N. Caroline St

19 (a) Filed by registrar AUG 4 1947 (b) Registered Washington Williamson

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1 1947, at 12 Mid night

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 1947, to Aug 1 1947, and that I last saw h alive on Aug 1 1947.

Immediate cause of death	Duration
Septic Intestinal Obstruction	7 days
Due to Followed by Septicemia	
Due to Multiple abscess	
Other Conditions Pregnancy	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. Kleinert M. D.
Address Johns Hopkins Hosp Date signed 8/4/47

X

G54022 — BALTIMORE CITY HEALTH DEPARTMENT — Newton — ✓ G54022

CERTIFICATE OF DEATH — 120a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 211 S. Collington ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 211 S. Collington ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna M. Newton

3 (b) If veteran, name war	3 (c) Social Security Account No.
c	c

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
Female	White	Widowed

6 (b) Name of husband or wife William F. Newton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22 1864

8. AGE: Years	Months	Days	If less than one day
83	5	9	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Edward Tolson
13. Birthplace Easton Shore

MOTHER
14. Maiden Name Mary Godnes
15. Birthplace Easton Shore

16 (a) Informant Copsey
(b) Address 211 S. Collington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 6 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Donald J. Lippel
(b) Address 315 S. Highland Ave

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 4 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-2-1947 at 2.20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-2-1947 to 8-2-1947 and that I last saw her alive on 8-1-1947

Immediate cause of death	Duration
Disease dehydration	2 weeks
Due to Intestinal infection + colitis ? T.B.	2 mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature S. Dumont M. D.
Address Medical Arts Bldg (Date signed)

G54023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

G54023
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 3-
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits write RURAL and give town)
(d) Street No. 917 S Style St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Koenig

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife: Child

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3. 1940

8. AGE: Years: 7 | Months: 1 | Days: - | If less than one day: hr. min.

9. Birthplace: Baltimore Md
(Town, county, and state)

10. Usual Occupation: School Child

11. Industry or business

FATHER
12. Name: Geage Koenig
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: Ethel Beales
15. Birthplace: Norfolk Va.

16 (a) Informant: Ethel Koenig
(b) Address: 917 Stiles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/6/47 (month) (day) (year)
(c) Cemetery or crematory: St Matthews
Location: Edmondson Ave

18 (a) Funeral director: Wardell Stoppel
(b) Address: 313 S. Hegleman Ave

19 AUG 4 1947 (b) Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3 1947 at 10:35 P.M.

21. I certify that I took charge of the remains described above, held an Aug 5 Insp thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Drowning

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Aug 3 1947 3/2 8:45 A.M.
(b) Where did injury occur? President St & Lancaster St
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? No
(d) Means of injury Fell into Harbor

23. Signature William J. McGuirk M.D.
Medical Examiner.
Date signed Aug 3rd 1947

54024

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G54024 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 340 S. Robinson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 2d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
2d Street No. 340 S. Robinson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis F. Smiglewski (Smigle)

3 (b) If veteran, name war —
3 (c) Social Security Account No. 215-09-6375

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Thelma Smiglewski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 24* 1909

8. AGE: Years 37 | Months 11 | Days 7 | If less than one day ..... hr. ..... min.

9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual Occupation: Route Salesman
11. Industry or business: Western Md. Dairy

FATHER
12. Name: Frank Smiglewski
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: Rose Pilachowska
15. Birthplace: Poland

16 (a) Informant: Mrs Thelma Smiglewski
(b) Address: 340 S. Robinson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 5th 1947 (month) (day) (year)
(c) Cemetery or crematory: Sacred Heart
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul St

AUG 5 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 1st 1947, at 6 13 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 46 to Aug 1 47, and that I last saw him alive on July 31 47.

Immediate cause of death	Duration
(a) Liver cancer	
Due to (b) Metastasis	
Due to (c) Liver cancer	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: J. Knox Insley M. D.
Address: 2936 E. Mal Date signed: 8-4-47

VS 150

G54025

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 931

Registered No. G54025

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 453 Whitridge
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 453 Whitridge Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen Blumenberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 1st 1867

8. AGE: Years	Months	Days	If less than one day
80	5	2	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Milliner

11. Industry or business

FATHER
12. Name Jan. Leopold Blumenberg
13. Birthplace Berlin, Germany

MOTHER
14. Maiden Name Emilie Knorr
15. Birthplace Alsace-Lorraine

16 (a) Informant Mrs. Helen Piccola
(b) Address 453 Whitridge Ave

17 (a) Burial (b) Date thereof 8/6/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Har Sinai
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

AUG 5 1947 (Huntington Williams M.D.)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/3/47 19 , at 4:15 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 8/3/47

G54026

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

99

G54026 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 512 S. Paca St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Angie Lavrana.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married,~~ widowed, or ~~divorced~~
Female	White	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-5-1864

8. AGE: Years	Months	Days	If less than one day
82 ~~85~~	11	25	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Lavrana
13. Birthplace Md.

MOTHER
14. Maiden Name Rebecca Mills
15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-5-47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Md.

18 (a) Funeral director Wilson & Son
(b) Address 1314 E. Cold St.

AUG 5 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1947, at 3.00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 1947, to July 30 1947, and that I last saw h[illegible] alive on July 30 1947.

Immediate cause of death	Duration
Thrombosis of Sup. Mesenteric A. due	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Theodore D. Stephen M. D.
Address Johns Hopkins Hospital Date signed 7-30-47

VS 150

54027

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G54027

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere & Bellona Aves.
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Towson Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 12 Aintree Road Wiltondale (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice S. Spalding

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife George Spalding
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1858

8. AGE: Years	Months	Days	If less than one day
88	11	1	hr. min.

9. Birthplace Fairfield, Penna. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Wintrode
13. Birthplace Penna.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr. Albert G. Kaiser
(b) Address 12 Aintree Road. Towson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 5, 1947 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Baltimore Co. Md.

18 (a) Funeral director William J. Tickner & Sons, Inc.
(b) Address North & Pennsylvania Ave.

AUG 5 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 2, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 29 1947, to Aug 2 1947, and that I last saw her alive on Aug 2 1947.

Immediate cause of death	Duration
Bronchio-pneumonia	2 days
Due to Cerebral Hemorrhage	3 wks
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Karl H. Benson, M.D.
Address 5111 York Rd Date signed 8/4/47

54028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G54028 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3720 Foster Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3311 Mueller St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Ott.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife George Ott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26, 1872

8. AGE: Years	Months	Days	If less than one day
74	10	8 7	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation house wife
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Lang
15. Birthplace Germany

16 (a) Informant George OTT
(b) Address 3311 Mueller St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/6/47 (month) (day) (year)
(c) Cemetery or crematory Schwartzs
Location O'Donnell St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.
(c) Date received by registrar AUG 5 1947 Washington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3 1947, at 1:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947, to Aug 3 1947, and that I last saw h alive on Aug 2 1947

Immediate cause of death	Duration
Myocardial Failure	4 mos.
Due to Chronic Myocarditis	7
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. H. Haskell M.D.
Address 627 S. Caroline St. Date signed 8/7/47

54029

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G54029

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2828 Harford Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto (If outside city or town limits, write RURAL, and give name)
(d) Street No. 3708 Liberty Heights Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederecke Marie Cassedy

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife, John Cassedy.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10 - 1872

8. AGE: Years	Months	Days	If less than one day
75	2	22	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business At home

FATHER
12. Name Christian Schell
13. Birthplace Germany

MOTHER
14. Maiden Name Louisa Roeder
15. Birthplace Baltimore

16 (a) Informant Mrs Lizzie B Knides
(b) Address 2921 E Federal St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 5th (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem
Location Woodlawn

18 (a) Funeral director Ulrich Funeral Home
(b) Address 200 E Oliver St

AUG 5 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15th 1947 at 6 P M

21. I certify that I took charge of the remains described above, held an Aug 2nd Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular
Due to disease
Other Conditions Obesity
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J Helfrich M.D. Medical Examiner.
Date signed Aug 1st 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

551030

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G54030

CERTIFICATE OF DEATH 121a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: Edmondson Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4yr 4mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Guilford
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Ernestine Massey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/30/1862

8. AGE: Years 84 | Months 7 | Days 13 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name unknown Negress
13. Birthplace Md

MOTHER 14. Maiden Name unknown
15. Birthplace "

16 (a) Informant Nathaniel Barnes
(b) Address Guilford Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-5-47 (month) (day) (year)
(c) Cemetery or crematory Good Shepherd
Location Elliott City

18 (a) Funeral director T C Hyatt Bottom
(b) Address Elliott City Md

(a) Date received by registrar AUG 5 1947 (b) Huntington Williams, M.D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug – 3 – 1947, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 – 1944, to Aug 3 1947 and that I last saw her alive on Aug 3d 1947.

Immediate cause of death: Cerebral Hemorrhage — Duration
Due to: Adv. arteriosclerosis
Due to:
Other Conditions: Chr. Nephritis
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis Jacob M. D.
Address 1700 Eutaw Pl (17) Date signed

× Aug. 4-1947

1031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G54031 Registered No. 13/a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3300 St Ambrose Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 3300 St. Ambrose Ave. 16 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Helen A. Mosmiller

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Leonard Mosmiller,
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7, 1868

8. AGE: Years	Months	Days	If less than one day
78	7	27	hr. min.

9. Birthplace Relay, Md. (Town, county, and state)
10. Usual Occupation Housewife,
11. Industry or business at home,

FATHER
12. Name Joseph Hellman,
13. Birthplace Germany,

MOTHER
14. Maiden Name unknown,
15. Birthplace Germany,

16 (a) Informant Mrs. J. Allen Broadbeck,
(b) Address 3300 St. Ambrose Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/6/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore City,

18 (a) Funeral director L. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

19 (a) (Date rec'd by Local Registrar) AUG 5 1947 (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 4, 1947 19 , at 8.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1920 to 8/4/47 1947, and that I last saw her alive on 8/3/47 1947.

Immediate cause of death	Duration
Uremia	3 days
Due to Hypertensive cardio-vascular Renal disease	10 yrs
Due to	
Other Conditions Senility	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1901 Eutaw Place, Date signed

X

G54032 LN. 85521

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G54032

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 927 Annapolis Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Wood (Married Name)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Wid.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 75 ? | Months | Days | If less than one day hr. min.

9. Birthplace ?
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Jones (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Kelty
15. Birthplace Md.

16 (a) Informant Records- Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 5 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director Joseph Neubauer
(b) Address Baltimore, Md.

19 AUG 5 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 2 1947 10:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-9 1943, to Aug. 2 1947, and that I last saw h[illegible] alive on Aug. 2 1947

Immediate cause of death	Duration
Pneumonia, Lobar	
Due to Bronchopneumonia,	
Due to Diffuse, bilat.	
Other Conditions Arteriosclerotic Cardio-Vascular Disease	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None.

of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Kelly, Jr. M. D.
Address Balto City Hosp. Date signed 3 Aug 47

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54033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓ G54033 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 N. Bond st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Archie Ball

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-3628

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife Geneva

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March ? 1892

8. AGE: Years	Months	Days	If less than one day
55	4		hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Saloon

11. Industry or business

FATHER
12. Name Thomas Ball
13. Birthplace Va

MOTHER
14. Maiden Name Mary ?
15. Birthplace Va

16 (a) Informant Geneva Ball
(b) Address N Spring St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 5-1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Baltimore Md

18 (a) Funeral director Robert V Williams
(b) Address 515 McElderry St

19 AUG 5 1947 Filed by registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23, 1947 at 6 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 7-24-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct as far as is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

- 2 -

54034

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 94a

Registered No. G54034

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be answered or "None," where correct. Do not use abbreviations. Do not write the age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) One
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Roseldale (If outside city or town limits, write RURAL and give town)
(d) Street No. 7903 3rd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Otto Storath

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Margaret E. J. Storath
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 6-1897

8. AGE: Years	Months	Days	If less than one day
50	-	28	hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual Occupation: Checker
11. Industry or business: Eastern Rolling Mills

FATHER
12. Name: Adolph B. Storath
13. Birthplace: Germany

MOTHER
14. Maiden Name: Mary Krebs
15. Birthplace: Delaware

16 (a) Informant: Margaret E. J. Storath
(b) Address: 3612 Fleet St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug. 8-47 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn Cem.
Location: Eastern Ave.

18 (a) Funeral director: John A. Miller
(b) Address: 2334 Jefferson St.

19 AUG 5 1947 (Date rec'd by registrar) Wellington Williams M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3 1947, at 8 50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary occlusion

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature: Earl L. Cozen M.D. (Medical Examiner)
Date signed 8-4-47

54035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G54035

Registered No. 170c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town White Marsh
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bartholomew B. Tremper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Elsie M. Tremper

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1904

8. AGE: Years	Months	Days	If less than one day
43	5	25	hr. min.

9. Birthplace Balto Co., Md.
(Town, county, and state)

10. Usual Occupation Truck Driver

11. Industry or business C. J. Langenfelder

FATHER
12. Name Leonard S. Tremper
13. Birthplace Balto Co. Md.

MOTHER
14. Maiden Name Margaret H Cook
15. Birthplace Balto Co. Md.

16 (a) Informant Mrs B.B. Tremper
(b) Address

17 (a) Burial (b) Date thereof 8/7/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Dorsey Cem.
Location Taylor Ave

18 (a) Funeral director Sandfn. Ferguson Bond
(b) Address 7701 Belair Rd.

AUG 5 1947
(Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4 1947, at 4:02 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull
Acute Meningitis
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-2-47 at 8:45 P.M. Balto. Co.
(b) Where did injury occur? Pulaski Highway & Bird River Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? no
(d) Means of injury Auto & Truck Collision

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 8-5-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

VS 151

G54036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1117a

Registered No. G54036

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 607
(c) Hospital or institution: Provident Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1da
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 604 W. Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel (Duncan) Dunkin

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	M

6 (b) Name of husband or wife Mattie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-/1902

8. AGE: Years	Months	Days	If less than one day
45	6		hr. min.

9. Birthplace Petersburg Va (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name James Dunkin
13. Birthplace Va

MOTHER
14. Maiden Name Susie Barnes
15. Birthplace Va

16 (a) Informant Mattie Dunkins
(b) Address 604 W. Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/6/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Pressman St

(a) Date rec'd AUG 8 1947 (Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/3/47 19 , at 9:15 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/2 19 47 to 8/3/47 and that I last saw h alive on 8/2 19 47

Immediate cause of death: Prob. Ruptured Gastric ulcer old

Duration

Due to Duodenal perforation old. Hemorrhage.

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. A. M. Johnson
Address Provident Hosp Signed 8/5/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

54037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

G54037

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 802 N. Mount St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edith Hillery

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Walter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/6/1909

8. AGE: Years	Months	Days	If less than one day
38	4	27	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)
10. Usual Occupation H. Wife
11. Industry or business

FATHER
12. Name James Tyler
13. Birthplace Md

MOTHER
14. Maiden Name Ella Brooks
15. Birthplace Md

16 (a) Informant Walter Fillery
(b) Address 802 N. Mount St

17 (a) Burial (b) Date thereof 8/7/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. G. Kelson Jr
(b) Address 1303 Pennsylvania Ave

AUG 5 1947
(Date rec'd by Registrar)

Huntington Williams M.D.
Registrar

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be answered. Write the causes of death clearly and legibly. Be correct age is especially important. Physicians: please write the

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/3 1947, at 12:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Stab wound of neck involving vessels of the carotid sheath

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-3-47 at 12:15 A.M.
(b) Where did injury occur? Mount & Lanvale Sts
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Stabbing c. sharp instr.

23. Signature Howard J. McGrath M.D.
Medical Examiner.
Date signed 8-4-47

1 X

G54038 BC# B85718 LM 112566

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G54038 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 221
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 117 W. Montgomery St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Byrd.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28-1947

8. AGE: Years | Months | Days: 2 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Israel Barnett
13. Birthplace N.C.

MOTHER
14. Maiden Name Mary E. Byrd.
15. Birthplace S.C.

16 (a) Informant Records Balto.City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremated (b) Date thereof 7/30/47 (month) (day) (year)
(c) cremation, crematory Baltimore City Hospitals
Location 4940 Eastern Ave (Records)

18 (a) Funeral director
(b) Address

AUG 5 1947 (Date rec'd by Registrar) (b) Thurlington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1947, at 11 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from July 28 1947 to July 30 1947 and that I last saw h im alive on July 30 1947.

Immediate cause of death Atelectasis — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulmonary atelectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Reynold H. Becker
Address Balto City Hosp Date signed 7/31/47

G54039 BCH 985696 JL - 112561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G54039 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Also correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 8 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 817 S. Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Aberts - Ruth

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1947

8. AGE: Years	Months	Days	If less than one day
			8 hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Aberts
13. Birthplace ?

MOTHER
14. Maiden Name Ruth Heuer
15. Birthplace Md.

16 (a) Informant Ba. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Cremated (b) Date thereof 7/30/47 (month) (day) (year)
(c) [redacted], cremation [redacted] crematory Baltimore City Hospitals
Location 4940 Eastern Ave (Records)

18 (a) Funeral director
Address

19 (a) AUG 5 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1947, at 11P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 28 1947, to July 28 1947, and that I last saw h[illegible] alive on July 28 1947

Immediate cause of death	Duration
Asphyxia neonatorum	
Due to atelectasis	1day
Due to Prematurity	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Gerald H. Baker
Address Balt City Hosp Date signed 7/31/47 M. D.

G54040 112612 LW

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 159

G54040 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Pasadena
(If outside city or town limits, write RURAL and give town)
(d) Street No. # 4 Water Oak Pt.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30, 1947

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Pasadena Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Raymond Hall
13. Birthplace Pa.

MOTHER
14. Maiden Name Stephanie Derriek
15. Birthplace Pa.

16 (a) Informant Records Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremated (b) Date thereof 7/31/47
(If not cremation, [illegible]) (month) (day) (year)
(c) [illegible] or crematory Baltimore City Hospitals
Location 4940 Eastern Ave (Records)

18 (a) Funeral director
(b) Address

19 (a) (Date rec'd by registrar) Aug 5 1947 (b) [illegible] Williams MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 19 47 at 5:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 1947, to July 30 1947, and that I last saw h im alive on July 30 19 47.

Immediate cause of death: Pneumonia & Atelectasis — Duration: 4 hours

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward H Becker M. D.
Address Balto City Hosp Date signed 7/31/47

X

G54041 Bl# B 83408 BALTIMORE CITY HEALTH DEPARTMENT G54041
CERTIFICATE OF DEATH 1600a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Turner Station (If outside city or town limits, write RURAL and give county)
(d) Street No. 709 Avondale Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Fossett
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex M. 5. Color or race Negro 6 (a) Single, married, widowed, or divorced
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 14, 1947
8. AGE: Years N.b. Months Days 3 If less than one day hr. min.
9. Birthplace Baltimore, Md (Town, county and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Archie Fossett
13. Birthplace Baltimore, Md.
MOTHER 14. Maiden Name Beulah Jackson
15. Birthplace Reba, Md.
16 (a) Informant Archie Fossett
(b) Address 709 Avondale Rd.
17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location
18 (a) Funeral director
(b)
19 (a) AUG 5 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1947, at 12 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from July 11 1947, to July 14 1947, and that I last saw him alive on 19
Immediate cause of death Anoxemia
Cerebral damage from
Central placenta previa
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature W. S. Butler, M.D.
Address Turner Station Date signed 7/16/47

VS 150

G54042

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Register No. G54042

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2600 Lauretta Ave.
(c) Hospital or institution: 16-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2600 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Billy Arthur Harris

3 (b) If veteran, name war

3 (c) Social Security Account No. 413-38-6980

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 5, 1929

8. AGE: Years	Months	Days	If less than one day
18	5	29	hr. min.

9. Birthplace St. Charles Va.
(Town, county, and state)

10. Usual Occupation Cashier

11. Industry or business Food Fair

FATHER
12. Name Jesse W. Harris
13. Birthplace Tennassee

MOTHER
14. Maiden Name Maggie Clarkson
15. Birthplace Tennassee

16 (a) Informant Maggo Harris
(b) Address 2600 Lauretta Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 10. 1947 (month) (day) (year)

(c) Cemetery or crematory Rose Hill
Location Rose Hill Virginia

18 (a) Funeral director George W. Littl
(b) Address 2700 Edmondson Ave.

19 AUG 5 1947 (Filed by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 3, 1947 19 , at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-3 1947 to 8-3 1947 and that I last saw him alive on 8-3 1947.

Immediate cause of death	Duration
Osteogenic Sarcoma right tibia	1 yr.
Due to	
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation Not done

Major findings of operation:

of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leon Gelman M. D.
Address 201 Pyles Annex Date signed 8/4/47

X

54043 BG#b 75407 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 157E Registered No. G54043

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2620 W. Franklin St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME David Rigney

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-7-47

8. AGE: Years	Months	Days	If less than one day
	3 4	27	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name David Rigney
13. Birthplace Md

MOTHER 14. Maiden Name Juanita Anderson
15. Birthplace Va.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 6. 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park.
Location

18 (a) Funeral director George W. Little
(b) Address 2329 Edmondson Ave

19 (a) AUG 5 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 4 1947 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1947 to Aug 4 1947 and that I last saw him alive on Aug 4 1947

Immediate cause of death	Duration
Congenital Heart Disease	Life
Due to with Heart Failure -	One week
Due to	
Other Conditions Acute Pharyngitis Acute Otitis Media	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Philip Brasier M.D.
Address Johns Hopkins Hosp Date signed 8-4-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54044

AB- 112518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 140 B

G54044 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 44days
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1134 Comet st. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lealee Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5- 1908

8. AGE: Years	Months	Days	If less than one day
39	1	26	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Benny Jones
13. Birthplace ?

MOTHER
14. Maiden Name Amy
15. Birthplace ?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/6/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Elon Addison

18 (a) Funeral director
(b) Address 1020 Brant Ave

19 AUG 5 1947 (Date rec'd by registrar) (b) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 1- 1947, at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-29- 1947, to 8-1- 1947, and that I last saw h[illegible] alive on 8-1 1947.

Immediate cause of death	Duration
Bronchopneumonia, Terminal	
Due to Pulmonary Tbc.	
Due to Infected abortion	3 mos.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: as above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Edmund Beacham
Address Balto City Hosp Date signed 3 Aug 47 M. D.

VS 150

X

C54045

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 8 3a

Registered No. C54045

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3301 Harford Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3301 Harford Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME IRENE BRESCIA PATURZO

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife Anthony Paturzo
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Apr. 8. 1881

8. AGE: Years	Months	Days	If less than one day
66	3	25	hr. min.

9. Birthplace Umbria — Italy
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Alexander Brescia
13. Birthplace Italy

MOTHER
14. Maiden Name Chiara Calucci
15 Birthplace Italy

16 (a) Informant Mr. S. A. Paturzo
(b) Address 3233 Kentucky Ave

17 (a) Entombment (b) Date thereof Aug. 3. 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Mausoleum
Location Baltimore Md.
18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address Baltimore Md.
19 (a) AUG 5 1947 (b)
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 3. 1947 at 12.52 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 14, 1945 to Aug. 3, 1947 and that I last saw her alive on Aug. 3, 1947

Immediate cause of death	Duration
Broncho Pneumonia	2 days
Cerebral Hemorrhage	5 years
Due to Arteriosclerosis	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Philibert Artigiani
Address 2942 E. Fayette St. Date signed 8/4/47

54046

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √170c

Registered No. G54046

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use typewriter if possible. Do not write the causes of death clearly and legibly. correct age is especially important. Physicians: please w

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 823 William St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME ~~Lawrence~~ Forman M. Rollinson

3 (b) If veteran, name war

3 (c) Social Security Account No. 228-14-5049

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 22, 1922

8. AGE: Years	Months	Days	If less than one day
25	3 2	13	..... hr. ..... min.

9. Birthplace Montgomery Cnty. Md
(Town, county, and state)

10. Usual Occupation Drill Digger

11. Industry or business

FATHER
12. Name Charles E. Rollinson
13. Birthplace Montgomery Cnty. Md.

MOTHER
14. Maiden Name Laurabell Harding
15. Birthplace Montgomery Cnty. Md

16 (a) Informant Norman F. Rollinson
(b) Address Leesburg, Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/6/47 (month) (day) (year)

(c) Cemetery or crematory Arlington Nat'l
Location Arlington Va.

18 (a) Funeral director Durand H. Blight Jr.
(b) Address 4914 Belair Road.

AUG 5 1947 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4 1947, at 12:50 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractures of skull
Rupture of Liver

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-4-47 at 12:15 A.M. Balto. Co.
(b) Where did injury occur? Endraum Road near Phila. Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? no Auto
(d) Means of injury Fell from moving car

23. Signature Earl L. Engel M.D.
Medical Examiner.

Date signed 8-4-47

VS 191

G54047

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 46 B

G54047 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5943 Falls Road
(c) Hospital or institution: --
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-12
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5943 Falls Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Amanda J. Garver

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-19-1860

8. AGE: Years	Months	Days	If less than one day
87	5	16	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business --

FATHER
12. Name Francis Garver
13. Birthplace Germany

MOTHER
14. Maiden Name Susanna Zimmerman
15. Birthplace Germany

16 (a) Informant Mr. Harry Wherley
(b) Address 5943 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-7-47 (month) (day) (year)
(c) Cemetery or crematory New Freedom Cem.
Location New Freedom, Penn.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

AUG 5 1947 (Date rec'd by Local Registrar) Huntington Williams, M.D. Registrar

V S 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 4 1947, at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1947 to Aug 4 1947, and that I last saw h[illegible] alive on Aug 4 1947.

Immediate cause of death: Ca of stomach - Generalized Carcinomatosis. — Duration: 7

Due to — Duration: ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Torrance H Hamaker M. D.
Address 3711 Falls Rd Date signed 8-5-47

X

54048

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G54048

Registered No. 106 B

Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County Frederick
(c) City or town Thurmont (If outside city or town limits, write RURAL and give town)
(d) Street No. RF # 1 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Blanche Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Charles Martin

6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) 10-15-13

8. AGE: Years 33 | Months 9 | Days 19 | If less than one day ... hr. ... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name William Carty

13. Birthplace Md.

MOTHER 14. Maiden Name Carrie Sweeney

15. Birthplace Md.

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 5-47 (month) (day) (year)

(c) Cemetery or crematory Lewistown Md

Location Near Thurmont Md.

18 (a) Funeral director M. L. Creager

(b) Address Thurmont Maryland

19 (a) Date rec'd by Registrar AUG 5 1947 (b) Registration No. Entered by Williams, M.R. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-4-1947, at 7:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-22-1947 to 8-4-1947, and that I last saw her alive on 8-4-1947.

Immediate cause of death: Cardiac failure, Congestive, acute — Duration 2 hrs

Due to: Post operative

Due to:

Other Conditions: Bronchiectasis. Post-op Rt Middle & Lower Pul. Lobectomy

(Include pregnancy within 3 months of death)

Date of operation 4 August 47

Major findings of operation: Bronchiectasis, LLL

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ... at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature James R. Cantrell M.D.

Address The Johns Hopkins Hosp. Date signed 8 Aug 47

G54049

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. G54049

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2320 Rosedale St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2320 Rosedale St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anna F Ellermann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~or wife~~ Albert C.

6 (c) If alive, give age 45 ~~years~~ 1903

7. Birth date of deceased (mo., day, yr.) Dec 18 ~~1902~~

8. AGE: Years ~~44~~ (45) | Months 7 | Days 17 | If less than one day ____ hr. ____ min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

MOTHER / FATHER

12. Name N. Emory Grey

13. Birthplace Md

14. Maiden Name Lillie Brinkmann

15. Birthplace Md

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/6/47 (month), (day), (year)

(c) Cemetery ~~or crematory~~ Cedar Hill

Location Ritchie Hwy

18 (a) Funeral director John F Delaney Inc

(b) Address 715 Light Street

19 (a) ____ (b) ____

Date rec'd by AUG 5 1947 Registrar VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 4 1947, at 2 ~~P~~ AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/19 1947, to 8/4 1947 and that I last saw ~~her~~ alive on Aug 3 1947

Immediate cause of death	Duration
Cerebral Degeneration	3 wks
Due to Cerebral embolic left prefrontal area	3½ mos.
Due to Hypertensive C-V disease Mitral stenosis - Auricular fibrillation	Ever 30 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel T. R. Revell, Jr.

Address 11 E. Chase St. Date signed 8/5/47

G54050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G54050

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 6-
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 124 N. Chapel Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES S. MILBURN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years 53 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore (town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant William Marshall
(b) Address 124 N Chapel St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-5-47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location B. & O.

18 (a) Funeral director Payne Sanders
(b) Address 417 E Preston St

19 (a) AUG 5 1947 (Date rec'd by registrar) (b) Huntington Wilkinson, M.D.

VS 131

PLEASE WRITE PLAINLY with unfading ink. Do not abbreviate. Be sure to write the causes of death clearly and legibly. Give exact cause of death correctly. Do not report symptoms, mode of dying, or conditions resulting from causes stated. Indefinite or incorrect statements of cause are especially important. Physicians: please write your address plainly.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1, 1947, at 9.15 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial hypertrophy and degeneration.

~~Duration~~ Edema of lungs

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.

Date signed 8/1/47

G54051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

G54051 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 635 S. Linwood Ave.
(c) Hospital or institution: — None —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 635 S. Linwood Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME George Mueller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Kunigunda Reisig

6 (c) If alive, give age yrs.

7. Birth date of deceased (mo., day, yr.) 11-14-1872

8. AGE: Years	Months	Days	If less than one day
74	8	19	— hr. — min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Copper Worker

11. Industry or business Copper

FATHER
12. Name George Mueller
13. Birthplace Germany

MOTHER
14. Maiden Name Ava Mueller
15. Birthplace Germany

16 (a) Informant Kunigunda Mueller
(b) Address 635 S. Linwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-6-47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Road

18 (a) Funeral director Libly & Zeiler Inc.
(b) Address 1403 W. Wolfe St.

AUG 5 1947 (Date rec'd by registrar) (b) Signature of Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3, 1947, at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1947 to August 1947 and that I last saw h[illegible] alive on Aug 1 1947

Immediate cause of death Cerebral Hemorrhage — Duration 12 hrs.

Due to Arteriosclerosis — 4 yrs.

Due to —

Other Conditions Diabetes Mellitus — 2 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clarence W. LeBoeuf

Address 601 S. Ellwood Ave Date signed 8/5/47

830a

G54052 BCH 85006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 159

Registered No. G54052

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be answered; if none, write NONE. If unknown, or if the question is not applicable, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1315 Aunt Ana Ave (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Baby Boy Williamson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 7-30-47

8. AGE: Years	Months	Days	If less than one day
		1	..... hr. ..... min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation.....
11. Industry or business

FATHER
12. Name William Williamson
13. Birthplace Md

MOTHER
14. Maiden Name Velma Hatt
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a)..... (Burial, cremation, or removal) (b) Date thereof..... (month) (day) (year)
(c) Cemetery or crematory
Loc[illegible] AUG 5 1947

18 (a) Funeral director Commissioner of Health
(b) Address.....

19 AUG 5 1947 (Date rec'd by local registrar) [illegible] Williamson M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 1 1947, at 10 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 31 1947, to 8-1- 1947, and that I last saw him alive on 8-1-47 19.....

Immediate cause of death	Duration
Prematurity	
Due to.....	
Due to.....	
Other Conditions.....	

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature [illegible]
Address Johns Hopkins Date signed 8-1-47 M. D.

X

1053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. C54053

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5219 Linden Hgts. Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 45 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 18
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5219 Linden Hgts Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: ROSE E. ROLLINGS

3 (b) If veteran, name war: None

3 (c) Social Security Account No. -

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband ~~or wife~~: Charles N. Rollings

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 3, 1881

8. AGE: Years 66 | Months 0 | Days 0 | If less than one day hr. min.

9. Birthplace Balto. Co. Md. (Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER
12. Name Henry Christy
13. Birthplace Pa.

MOTHER
14. Maiden Name Alice Greaser
15. Birthplace Balto. Co. Md.

16 (a) Informant Miss. Olga M. Rollings
(b) Address 5219 Linden Hgts. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/6/47 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Moreland Mem. Ch.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

19 (a) AUG 5 1947 (Date rec'd by registrar) (b) Huntington Hollinsworth, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 3, 1947 19 , at 9:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 17 1947 to Aug 3 1947, and that I last saw h[illegible] alive on Aug 1 1947

Immediate cause of death: Cerebral Thrombosis — Duration: One Year

Due to: Arteriosclerosis

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. E. Jones M.D.

Address 2818 St. Paul St. Date signed 8/4/47

G54054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 124 B

Registered No. G54054

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be made on this certificate before any burial or removal is authorized. Use only standard abbreviations. Do not use ditto marks. Be sure to fill in every item. If unknown, insert "unknown" or "none" so as to show that no information has been omitted. Write the cause of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1301 Park Ave.
(c) Hospital or institution: Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) ? 12-6
(e) Length of stay in Baltimore (yrs., mos., or days) since 1 yr. old

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County City of Baltimore
(c) City or town Baltimore City. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2736 Maryland Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Ella Louise Hughes

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Harry E. Hughes
6 (c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) June-27-1867

8. AGE: Years 80 | Months 1 | Days 8 ? | If less than one day ____ hr. ____ min.

9. Birthplace Howard Co., Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Thomas H. Marks
13. Birthplace England

MOTHER
14. Maiden Name Mary Jane Clark
15. Birthplace England

16 (a) Informant Mrs. Ella L. Hughes(deceased)
(b) Address 2736 Maryland Ave., City.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug -7-1947 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore

18 (a) Funeral director Stewart & Mowen Company
(b) Address 1914 North-Av., City.

19 (a) AUG 5 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 August 1947, at 11 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 30 1947 to Aug 4 1947 and that I last saw h.. alive on 4 Aug 1947

Immediate cause of death	Duration
Pneumonia, terminal	4 days
Due to arthritis, multiple	4 years
Due to cirrhosis liver	3 years
Other Conditions Inguinal hernia, hemorrhoids. (Include pregnancy within 3 months of death)	

Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Randolph R. Smith, Jr. M. D.
Address 1014 St Paul St Date signed Aug 5, 47.

G54055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

G54055 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given. If unknown, write "unknown." Be sure to correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2007 Stonewood Rd.
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 9 4
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2007 Stonewood (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Blanche Bent

3 (b) If veteran, name war none — 3 (c) Social Security Account No. none

4. Sex Female — 5. Color or race White — 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Jos. G. Bent

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 11 1874

8. AGE: Years 72 | Months 10 | Days 24 | If less than one day hr. min.

9. Birthplace Gloucester, Mass (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name Jos. Slattery
13. Birthplace Cape Breton Island

MOTHER
14. Maiden Name Johanna O'Toole
15. Birthplace Cape Breton Island

16 (a) Informant Maj. Jos. G. Bent Jr. (son)
(b) Address Arlington, Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-6-47 (month) (day) (year)
(c) Cemetery or crematory Holy Rood
Location Boston, Mass.

18 (a) Funeral director Stewart Morrill
(b) Address 108 W. Monument

19 (a) AUG 5 1947 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 4, 1947 at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 1943 to Aug 4, 1947 and that I last saw h[illegible] alive on Aug. 3, 1947.

	Duration
Immediate cause of death: Cerebral hemorrhage	3 days
Due to Arteriosclerosis	10 yrs.
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John H. Trescher
Address 1035 N. Calvert St. Date signed 8/5/47

VS 150

G54056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G54056

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 228 S Green St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANASTASIA PADNUK.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Andrew
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years: 62 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: Housework

11. Industry or business: —

FATHER
12. Name: ?
13. Birthplace: ?

MOTHER
14. Maiden Name: ?
15. Birthplace: ?

16 (a) Informant: Andrew Padnuk
(b) Address: 228 S. Green St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug 6-47 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Rd

18 (a) Funeral director: Joseph Kaminskas
(b) Address: 607 Washington Blvd

19 (a) AUG 5 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 3 19 47 at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 3 1947 to Aug 3 1947 and that I last saw h. alive on Aug 3 19 47.

Immediate cause of death	Duration
Cong Active Heart Failure	6 wks.
Due to Coronary Occlusion	1 day?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Oscar Kaufman M. D.
Address: Sinai Hospital Date signed: Aug 3/47

G54057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

64 Schonfield / 30 F

G54057 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3110 Savoy Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3110 Savoy Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gloria M Evans

3 (b) If veteran, name war: N
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 17, 1928

8. AGE: Years: 19 | Months: 1 | Days: 18 | If less than one day: hr. min.

9. Birthplace: Ewell Md (Town, county, and state)

10. Usual Occupation: Home

11. Industry or business

FATHER
12. Name: Thomas C Evans
13. Birthplace: Ewell Md

MOTHER
14. Maiden Name: Ellington Farnhansen
15. Birthplace: Galts Md

16 (a) Informant: Mrs Ellington Evans
(b) Address: 3110 Savoy Ave

17. Burial (Burial, cremation, or removal) (b) Date thereof: 8/9/47 (month) (day) (year)
(c) Cemetery or crematory: Huston Md
Location: Baltimore Md

18 (a) Funeral director: Mathews & Son
(b) Address: 1219 E Fayette St

19 AUG 6 1947 Date rec'd by Registrar: Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 5 1947, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 29 1947 to Aug 5 1947 and that I last saw h PM alive on July 4 1947.

Immediate cause of death: Congenital Syphilis
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration
Lifetime

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Schonfield
Address 801 Cathedral Date signed 8/5/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Fill in the cause of death clearly and legibly. Physicians: please write the correct age is especially important.

54058 BALTIMORE CITY HEALTH DEPARTMENT G54058

CERTIFICATE OF DEATH 186a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be accurately correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Colvert Sts.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31 days
(e) Length of stay in Baltimore (yrs., mos., or days) 82 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 323 Broxton Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ida A. Coleman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 3, 1865

8. AGE: Years 82 | Months 6 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER 12. Name John T. Coleman
13. Birthplace Maryland.

MOTHER 14. Maiden Name Julia Floyd.
15. Birthplace Maryland

16 (a) Informant Frank J. Coppuja
(b) Address 323 Broxton Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/8/47 (Month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore, Md.

18 (a) Funeral director Wilson & Son
(b) Address 1217 E. Fayette St.

AUG 6 1947 (Date received) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 5 1947, at 9.45A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 3 1947, to Aug 5 1947, and that I last saw h-er alive on Aug 5 1947.

Immediate cause of death	Duration
Acute pulmonary edema	
Due to Left Ventricular Heart Failure	
Due to A.S.H.D.	
Other Conditions Greatly Enlarged Heart + Severe Interstitial Fat Necrosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 7/12
(a) Accident, suicide, or homicide Accident Homicide
(b) Date of occurrence June 29 1947 at M
(c) Where did injury occur? Balt. (City or town) Balt. (County) Md (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home. (Specify type of place) While at work? No
(e) Means of injury Fall down stairs

23. Signature H. A. Smeltzer M. D.
Address Union Memorial Hosp. Date signed

Howard J. Mendelsohn M.D. 8/15/47

G54059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G54059 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 416 W. 25th Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 416 W. 25th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stephen Gunther

3 (b) If veteran, name war: 10

3 (c) Social Security Account No. none

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Stella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5. 1877

8. AGE: Years: 70 | Months: 5 | Days: - | If less than one day: hr. min.

9. Birthplace: Baltimore Md
(Town, county, and state)

10. Usual Occupation: Laborer Retired

11. Industry or business

FATHER 12. Name: Hammond Gunther
13. Birthplace: Taylor Co Md

MOTHER 14. Maiden Name: Elizabeth Gondy
15. Birthplace: Talbot Md

16 (a) Informant: Mrs. J. Gunther
(b) Address: 416 W 23rd St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/8/47 (month) (day) (year)

(c) Cemetery or crematory: Lorraine
Location: Parkville Md

18 (a) Funeral director: Wilhom & Dorsey
(b) Address: 1217 E Fort Ave

AUG 6 1947 Huntington Williams M.D.
(Date rec'd by Local Registrar) (Signature of Local Registrar)

VS 151

PLEASE WRITE PLAINLY, WITH INK. Be sure to give the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/5/47 1947 at 6 A.M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 8/5/47

51060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

G54060 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address BROADWAY ST.
(c) Hospital or institution: CHURCH HOME INSTITUTE
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) year

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 204 Longwood Rd.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country Longwood

3 (a) FULL NAME GORDON, BASIL Basil Gordon

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. 577-18-4403

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: HELEN W. GORDON

6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) 1-18-1896

8. AGE: Years 51 | Months 6 | Days 17 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Journalist

11. Industry or business Newspaper

FATHER 12. Name Basil Gordon

13. Birthplace Md

MOTHER 14. Maiden Name Celia Montague

15. Birthplace Md.

16 (a) Informant Mrs. S. Walker

(b) Address Richmond, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 6 1947 (month) (day) (year)

(c) Cemetery or crematory Green Mount

Location Balto Md

18 (a) Funeral director Henry W. Jenkins Sons & McCullough Richardson

(b) Address [illegible]

AUG 6 1947 (Date filed by Registrar) Washington Williams M.D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 August 1947, at 8:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4 Aug. 1947 to 4 Aug. 1947 and that I last saw h[illegible] alive on 4 Aug 1947

Immediate cause of death	Duration
Mesenteric thrombosis	
Due to Rocky Mountain Spotted Fever	3 days
Due to SEPTICEMIA, ETIOLOGY UNKNOWN	
Other Conditions (Include pregnancy within 3 months of death)	

Date of operation .....

Major findings of operation: .....

of autopsy: Gangrene of Intestine

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....

23. Signature [illegible] M. D.

Address [illegible] Date signed 5 Aug '47

54061

430707

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 61

G54061

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be answered or the word "unknown" or the correct word inserted. Physicians: please write the causes of death clearly and legibly. Please correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 239 E Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) FULL NAME Belle M. Mc Cormick (Caroline I. McCormick)

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 163-03-7916

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Thomas C. McCormick

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) 9-28-80

8. AGE: Years 66 | Months 10 | Days 8 | If less than one day ..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name John Hamilton
13. Birthplace Md.

MOTHER
14. Maiden Name Marie ?
15. Birthplace Md.

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/8/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Avenue Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 AUG 6 194 Received by [redacted] Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 5- 1947 at 2 30/AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-29- 1947 to 8-5- 1947 and that I last saw her alive on 8-5- 1947.

Immediate cause of death: Acute Myocardial Infarction — Duration 24hrs

Due to: Arteriosclerosis

Due to.....

Other Conditions: Diabetes Mellitus 2 yrs. Gangrene (Include pregnancy within 3 months of death)

Date of operation: 0

Major findings of operation:.....

Findings of autopsy: Scarred infarct & fresh infarction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?.....
(e) Means of injury.....

23. Signature James R. Carter M. D.
Address The Johns Hopkins Hospital Date signed 5 Aug 47

94a

5 51062

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G51062
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Physicians: please write correct age is especially important. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital, Balto., Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 132 days
(e) Length of stay in Baltimore (yrs., mos., or days) 132 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mass. (b) County
(c) City or town Gloucestor
(If outside city or town limits, write RURAL and give town)
(d) Street No. 22 Concord Street (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME
Bert Henry Poirier

3 (b) If veteran, name war
3 (c) Social Security Account No. None

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Christina Poirier
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) March 3, 1895

8. AGE: Years 52 | Months 5 | Days 1 | If less than one day: hr. min.

9. Birthplace: Cape Britain, Nova Scotia (Town, county, and state)
10. Usual Occupation: Captain
11. Industry or business: Seafarer

FATHER
12. Name: Philip Poirier
13. Birthplace: Nova Scotia

MOTHER
14. Maiden Name: Mary Poirier
15. Birthplace: Nova Scotia

16 (a) Informant: Records
(b) Address: U. S. Marine Hospital, Balto., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 9-47 (month) (day) (year)
(c) Cemetery or crematory Beechbrook
Location Gloucester Mass

18 (a) Funeral director Edgworth Armacost
(b) Address 391 Liberty Heights Ave

AUG 6 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4 1947, at 2:00PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 25 1947, to Aug. 4 1947, and that I last saw him alive on Aug. 4 1947.

Immediate cause of death: Hypostatic pneumonia — Duration: 4 days

Due to: Carcinoma of rectum with massive metastases to liver, lungs and a few nodules of tumor in lower lobes of lungs. — Duration: unknown

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M.D.
Address USMarine Hospital, Balto. Md. Date signed 8/5/47

VS 180

54053 Sauerland

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 937

Registered No. G54063

Every item of information must be answered. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1527 Poplargrove St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry C Sauerland

3 (b) If veteran, name war

3 (c) Social Security Account No. 230-20-2047

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Jeannette Sauerland
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23 1871

8. AGE: Years	Months	Days	If less than one day
76	0	12	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Sheet metal worker
11. Industry or business Retired

FATHER
12. Name Henry C Sauerland
13. Birthplace Germany

MOTHER
14. Maiden Name Betty Schmidt
15. Birthplace Germany

16 (a) Informant Jeannette Sauerland
(b) Address 1527 Poplargrove St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Aug 8-47 (month) (day) (year)
(c) Cemetery or crematory Westview
Location

18 (a) Funeral director Chas P Powell
(b) Address 2417 Edmondson Ave

AUG 6 1947 (b) Huntington Williams (Date rec'd by local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 1947 to Aug. 5 1947 and that I last saw him alive on August 5 1947.

Immediate cause of death Congestive Heart Failure — Duration

Due to Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. A. Hightower M. D.
Address University Hospital Date signed 8-5-47

1064 LW 96417 BALTIMORE CITY HEALTH DEPARTMENT G54064
CERTIFICATE OF DEATH 13B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26-12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr.
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Orderly's quarters B C H (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bernard Otten

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28, 1887

8. AGE: Years 60 | Months 6 | Days 6 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Joseph Otten
13. Birthplace Md.

MOTHER 14. Maiden Name Julia Dorn
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/6/47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Gorsuch & Hillen Rds

18 (a) Funeral director John J. Fahey Sons
(b) Address 1815 Light St.

AUG 6 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 3 1947, at 8:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-2 1945, to Aug. 3 1947, and that I last saw him alive on Aug. 3 1947.

	Duration
Immediate cause of death: respiratory failure	2wks
Due to: Tuberculosis of lungs	2yrs
Due to:	
Other Conditions: Hemorrhaged arterio-sclerosis with hypertension (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph J. Bowen Jr. M. D.
Address Balto City Hospitals Date signed 8-4-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Please write the causes of death clearly and legibly. Physicians: please write correct age. age is especially important.

54065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

935 ✓

Registered No. G54065

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1046 Pennsylvania Ave
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Eliza Gerald

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 15, 1867

8. AGE: Years	Months	Days	If less than one day
80	4	20	....hr. ....min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation.....
11. Industry or business

FATHER
12. Name Edmund
13. Birthplace Va.

MOTHER
14. Maiden Name Winnie Jackson
15. Birthplace Va.

16 (a) Informant Annie Ware
(b) Address 1046 Penna. Ave.

17 (a) Burial (b) Date thereof 8-8-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location.....

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

AUG 6 1947
(Date rec'd by registrar)

Funeral Director for Williams, Mgr.

VS 191

MEDICAL CERTIFICATION 30

20. DATE OF DEATH 8-4-1947, at 9 P.M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH.....
Arteriosclerotic cardio-vascular disease

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 8/5/47

PLEASE WRITE PLAINLY. Physicians: please write the correct age is especially important.

4066

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G54066 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 726 North Eutaw (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD Holmes

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-03-4194

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1887

8. AGE: Years	Months	Days	If less than one day
59	9	2	hr. min.

9. Birthplace Edgefield, S. C. (Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business

FATHER
12. Name Sam Holmes
13. Birthplace

MOTHER
14. Maiden Name Laura Griffin
15. Birthplace

16 (a) Informant Hattie Holmes
(b) Address 726 Eutaw Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-9-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

AUG 6 1947 (Date rec'd by Registrar) Washington Williams Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/5/47 19..., at 12:10 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Stevens M.D.
Medical Examiner.
Date signed 8/5/47

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1067

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30D ✓

Registered No. G54067

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Providential Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 824 Druid Hill ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Tates

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Simon Tates
13. Birthplace Maryland

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Lydia Fisher
(b) Address 824 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-9-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) AUG 6 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION 30

20. DATE OF DEATH 8/3 1947, at 12 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Ruptured aneurysm of aorta with hemorrhage into pericardial cavity.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at A.M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner.
Date signed 8/4/47

PLEASE WRITE PLAINLY. Physicians: please write the cause of death clearly and report correct age is especially important.

54068 LR 79196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G54068 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 951 Etting St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nettie Torney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9, 1871

8. AGE: Years 75 | Months 7 | Days 21 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Oliver
13. Birthplace Va.

MOTHER
14. Maiden Name [illegible]
15. Birthplace Va.

16 (a) Informant Records Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-7-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location G.G. Lot No.

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

AUG 6 1947 (Date rec'd by Registrar) (Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1947 8:10 pm

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 14 1943 to July 30 1947, and that I last saw her alive on July 30 1947

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Hypertensive-Sclerosis-Coronary Heart Disease	
Due to	
Other conditions Pneumonia, Bronchiectasis, Accident (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation

of autopsy Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. R. Scarborough M. D.
Address Balto City Hosp Date signed 8-4-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

VS 150

C54069

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

C54069 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CHLVERT 433 N. Fr.
(c) Hospital or institution: UNIV MEMORIAL HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 106 W. UNIV. PARKWAY (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME HELEN OREN CRITCHLEY

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: FEMALE
5. Color or race: W
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: CHARLES CRITCHLEY
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug. 3, 1890
8. AGE: Years 57 | Months 0 1 | Days 0 1 | If less than one day hr. min.
9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name HUGH OREN
13. Birthplace BALTO, MD

MOTHER
14. Maiden Name IDA FOUST
15. Birthplace CONNECTICUT

16 (a) Informant HUSBAND
(b) Address 106 W. UNIV. PKWY, BALTO, MD

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/7/47 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Woodlawn
Location Woodlawn Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves Balto. 17, Md.

AUG 6 1947 (Date rec'd by Reg. or Asst. Reg.) (b) Huntington Williams, M.D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Be sure age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 3 1947, at 1:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1 1947, to Aug. 3 1947, and that I last saw her alive on Aug. 3 1947.

Immediate cause of death	Duration
PULMONARY EDEMA (Final)	
Due to ACUTE [redacted] FAILURE	
Due to INTESTINAL OBST. HEPATONEPHLY, PORTAL CIRRHOSIS	
Other Conditions FRAC. R. T. ANKLE	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Confirmation of Diagnosis.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ACCIDENT
(b) Date of occurrence 8/1/47 at 9 A M
(c) Where did injury occur? [redacted] BALTO, MD. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? [redacted] While at work? [redacted] (Specify type of place)
(e) Means of injury Fell down steps - fracture ankle - not stated
23. Signature [redacted] Coroner [redacted]
Address [redacted] Date signed

Howard J. Haslam, M.D. 8/4/47

G54070

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G54070

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given. Every question must be answered. Where the exact information is not known, the best possible estimate should be given. Do not use abbreviations. Be sure that the cause of death is stated so as to show clearly the disease, if any, which originated the fatal train of morbid conditions resulting in death, and the primary cause of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1506 North Division St
(c) Hospital or institution:
Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Thomas.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Widower,
6 (b) Name of husband or wife: Jennie Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 5, 1897

8. AGE: Years 49 | Months 10 | Days 28 | If less than one day hr. min.

9. Birthplace Calvary County, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name Martha ?
15. Birthplace Calvary County, Md.

16 (a) Informant William J. Thomas
(b) Address 1205 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 7, 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 AUG 6 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/3/47, 19, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/3/47 19 to 8/4/47 19, and that I last saw h alive on 19

Immediate cause of death Intestinal Obstruction acute.
Due to
Due to
Other Conditions Hypertensive Heart Dis. Ofes. Nephritis
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy Old adhesion following

Duration

22. If death was due to external causes, fill in also the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. B. Harris / Robinson
Address President Hosp. Date signed 8/5/47

PHYSICIAN
Underline the cause to which death should be charged statistically.

54071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G54071

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dot
(e) Length of stay in Baltimore (yrs., mos., or days) Dot

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 786 W. Lanvale (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Bailey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Sadie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 27, 1879

8. AGE: Years 68 | Months 5 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Janitor
11. Industry or business

FATHER
12. Name John A. Bailey
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Alice Boyd
15. Birthplace Baltimore, Md

16 (a) Informant Mrs. Agnes Jones
(b) Address 314 N. Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 6, 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md

18 (a) Funeral director Geo. H. Hall & Son
(b) Address 1631 Druid Hill Ave

AUG 6 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/3/47 19..., at 7.01 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D. Medical Examiner.
Date signed 8/4/47

X

G54072

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 129

G54072 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be answered. If none, say so. Do not leave a space blank. Be sure the cause of death is clearly and legibly stated. Physicians: please write the correct cause of death clearly and legibly. Every item is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun Sts
(c) Hospital or institution
Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Owings
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Geneva Curtis
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-12-29

8. AGE: Years	Months	Days	If less than one day
18	3	24 23	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Ellis Curtis
13. Birthplace Maryland

MOTHER
14. Maiden Name Melba Wallace
15. Birthplace Maryland.

16 (a) Informant: Geneva Curtis
(b) Address Owings Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Fredericksburg
Location Fredericksburg Md

18 (a) Funeral director W. H. Tolchinson & Son
(b) Address

19 (a) AUG 6 1947 (Date received by registrar) (b) Thurlington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/5/1947 at 11:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/4 1947 to 8/5 1947 and that I last saw h[illegible] alive on 8/5 1947.

Immediate cause of death: Generalized Peritonitis — Duration: 1 day at this hospital

Due to: Cause undetermined

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Generalized Peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Michael R. Rasmussen M. D.
Address Fkln Sq Hospital Date signed 8/6/47

G54073 Killmeyer 94a G54073

BALTIMORE CITY HEALTH DEPARTMENT
Registered No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument Street
(c) Hospital or institution:
Sinai Hosp. 11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1207 N. Calvert St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROSE KILLMEYER

3 (b) If veteran, name war: None
3 (c) Social Security Account No.:
4. Sex: Female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife:
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr) Apr-6-1892
8. AGE: Years 55 | Months 4 | Days - | If less than one day hr. min.
9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Saleswoman
11. Industry or business Rosenfeld Rohr Co.
FATHER 12. Name August Killmeyer
13. Birthplace Baltimore, Md.
MOTHER 14. Maiden Name Adelina Mispelhaus
15. Birthplace Baltimore, Md.
16 (a) Informant Mrs. Marie Weber
(b) Address 1207 N. Calvert St.
17 (a) Cremation (b) Date thereof 8-6-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem
Location Balto Md.
18 (a) Funeral director Wm J. Jackson & Co
(b) Address Balto Md.
19 1947 (Date rec'd by) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/6/1947, at 6.10 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 7/19/1947 to 8/6/1947 and that I last saw h. alive on 8/6/1947.

Immediate cause of death	Duration
Myocardial insufficiency	
Due to coronary sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Irmi Cohen M.D.
Address Sinai Hosp. Date signed 8/7/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be answered; if unknown, write the causes of death clearly and legibly. Correct age is especially important. Physicians: please write

VS 150

G54074

BALTIMORE CITY HEALTH DEPARTMENT ✓ G54074 Registered No.

CERTIFICATE OF DEATH 1318

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 123 W. Hamburg (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Elizabeth Jones White

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Married

6 (b) Name of husband or wife [redacted] David White
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 26, 1918

8. AGE: Years	Months	Days	If less than one day
29	5	11	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Pete Jones
13. Birthplace North Carolina

MOTHER
14. Maiden Name Lucille Welsh
15. Birthplace North Carolina

16 (a) Informant David White
(b) Address 123 W. Hamburg St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 8 47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A A Co Md

18 (a) Funeral director Isaiah L Brown Son
(b) Address 1084 Montgomery St

19 (a) 1947 (Date rec'd by registrar) (b) Registrar Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 5 1947, at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 28 1947, to Aug 5 1947, and that I last saw her alive on Aug. 5 1947.

	Duration
Immediate cause of death Uremia	
Due to Chronic glomerulo-nephritis	3 months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Johnson M. D.
Address Mercy Hospital Date signed 8/5/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

VS 150

G54075

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G54075 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2103 Lake Montebello Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2103 Lake Montebello Terrac
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME OLGA SCHUERHOLZ

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Richard H. Schuerholz
6 (c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): Jan. 12. 1871

8. AGE: Years 76 | Months 6 | Days 23 | If less than one day ....hr. ....min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: William Kispert
13. Birthplace: Germany

MOTHER
14. Maiden Name: Katherine Weber
15. Birthplace: Germany

16 (a) Informant: Richard Schuerholz
(b) Address: 2103 Lake Montebello Terr.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug. 7. 1947 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Baltimore Md.

18 (a) Funeral director: HENRY SANDER & SONS. INC.
(b) Address: Baltimore Md.

6 (a) 1947 (Date received by registrar) Herbert Williams M.D. Registrar

V S 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Exact age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4, 1947, at 10.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1947 to Aug 4 1947. and that I last saw her alive on June 18 1947.

Immediate cause of death	Duration
Acute Coronary Occlusion	1 day
Due to Arteriosclerotic Heart Disease.	5 years
Due to	
Other Conditions.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ....at ....M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Geo. Dawson
Address: 4808 Harford Rd. Date signed: 8/5/47

X

G54076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13/a

G54076 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry must be complete and correct as to the causes of death clearly and legibly. Physicians: please write especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 406 N. LAKEWOOD
(c) Hospital or institution:
— NONE —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 406 N. LAKEWOOD
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country — — —

3 (a) FULL NAME MINNIE SCHEPER

3 (b) If veteran, name war — — —

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. WIDOWED

6 (b) Name of husband or wife CHARLES SCHEPER

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 6-5-1884

8. AGE: Years 63 | Months 1 | Days 29 | If less than one day ..... hr. ..... min.

9. Birthplace BALTIMORE, MARYLAND
(Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business HOME

FATHER
12. Name JOSEPH RIEGELMAN
13. Birthplace GERMANY

MOTHER
14. Maiden Name ANNA LAKE
15. Birthplace BALTIMORE, MD.

16 (a) Informant MARIE PUCKHABER
(b) Address 1010 S. KENWOOD AVE.

17 (a) BURIAL (b) Date thereof 8-7-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD.

18 (a) Funeral director LILLY + ZEILER INC
(b) Address 403 S. WOLFE ST. (31)

19 1947 (b) Registrar
(Date rec'd by registrar)
Huntington Williams, MD

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 4, 1947, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1, 1938 to August 4 1947, and that I last saw h[illegible] alive on August 4 1947.

Immediate cause of death	Duration
Acute Cardiac failure	1 day
Due to Cardio-Vascular-Hypertensive disease	9 years
Due to Arteriosclerosis	9 years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Michael J. Drusch M. D.
Address 1 W. Chesapeake Ave. Date signed 8/6/47

X

G54077

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

181

✓ G54077

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: U.S. Marine Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.J. (b) County
(c) City or town Nwk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 342 613 E - Cat 2.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Russia -

3 (a) FULL NAME Nicholas B. Baladon (BALADIN)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. 057-12-9469

6 (b) Name of husband or wife Unr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10 1888

8. AGE: Years 59 | Months 2 | Days 24 | If less than one day ..... hr. ..... min.

9. Birthplace Russia -
(Town, county, and state)

10. Usual Occupation Fireman water tender

11. Industry or business Seafarer.

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof 8-7-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St Matthai
Location O'Donnell St.

18 (a) Funeral director Tilly & Zeiler, Inc.
(b) Address 403 S. Wolfe St. Balto.

19 (a) 1947 (b)
(Date received by registrar) Registrar

VS 151

Phantiring for Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-3- 1947 at 7 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Extensive second- and third-degree burns of back and legs, with infection.

Due to
Myocardial degeneration.
Early bronchopneumonia

Other Conditions
Acute ulceration of stomach.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8/5 at 11/1 8 P.M.
(b) Where did injury occur? Nat. Royal Hotel
(c) Did injury occur at home, on farm, industrial place, in public place? Hotel While at work? No
(d) Means of injury Fell Pushed into tub of water

23. Signature George G. Merkle M.D.
Medical Examiner
Date signed 8/4/47

X

G54078 BALTIMORE CITY HEALTH DEPARTMENT ✓ G54078

BC# 9386476 CERTIFICATE OF DEATH 1579 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST
(c) Hospital or institution:
ST. JOSEPH'S HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE - 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2403 McELDERRY ST
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MARY SMITH

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/26/47

8. AGE: Years	Months	Days	If less than one day
0	0	10	hr. min.

9. Birthplace Portsmouth Va
(Town, county and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Cemon M. Smith
13. Birthplace Md

MOTHER
14. Maiden Name Bertha Eichhardt
15. Birthplace Md

16 (a) Informant Cemon M. Smith
(b) Address 2403 McElderry

17 (a) Buried (b) Date thereof 8-6-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Frank Burdelow
(b) Address 2604 Aliceanna

19 (a) 1947 (b)
(Registered by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5 19 47, at 9.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 19 47 to Aug 5 19 47, and that I last saw h alive on July Aug 5 19 47

Immediate cause of death	Duration
(a) PERITONITIS	
Due to (b) BREAKDOWN OF GASTROENTEROSTOMY	
Due to (c)	
Other Conditions ATRESIA, DUODENUM	

(Include pregnancy within 3 months of death)
Date of operation July 30, 1947
Major findings of operation: ATRESIA, DUODENUM
of autopsy ATRESIA OF DUODENUM PERITONITIS

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Harry P. Porter
Address St. Joseph's Hosp Date signed 8/6/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use typewriter if possible. Be sure to write the causes of death clearly and legibly. Do not abbreviate. Omit age is especially important. Physicians: please write your name and address.

G54079
CM. 109884

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G54079 Registered No. 14

PLEASE WRITE PLAINLY, WITH UNFADING INK. Fill all blanks. Give the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 3 Months
(e) Length of stay in Baltimore (yrs., mos., or days) 7 Weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4618 Curtis AVE. Z 26
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ashby Robert Colvin

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16 -1944

8. AGE: Years	Months	Days	If less than one day
2	10	18	hr. min.

9. Birthplace England
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Ashby Parker Colvin
13. Birthplace VA.

MOTHER
14. Maiden Name Jean Murial Wawl
15. Birthplace England

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern AVE.

17 (a) Burial (b) Date thereof 8/6/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A. A. Co.

18 (a) Funeral director C. J. Fanning & Son
(b) Address 438 E. Lafayette Ave.

19 (a) AUG 6 1947
(Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 4 - 1947, at 6.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 14 19 47 to Aug. 4 19 47, and that I last saw h. in alive on Aug. 4 - 19 47.

Immediate cause of death	Duration
Tuberculous Meningitis	3½ mos.
Due to	
Due to	
Other Conditions Right Hemiparesis	3 wks.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Tbc Meningitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Julian P. Griffin M. D.
Address Balt. City Hosp. Date signed Aug 5 1947

G54080

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47F

Registered No. G54080

PLEASE WRITE PLAINLY, WITH UNFADING INK. Enter the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave. at Madison
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4312 Penhurst Ave (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Viola F. Mulkay.
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced. married
6 (b) Name of husband or wife David P. Mulkay
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 2, 05, 1889
8. AGE: Years 58 Months 6.5 Days 4 9 If less than one day hr. min.
9. Birthplace Phila Pennsylvania (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Richard Nichols
13. Birthplace Philadelphia, Pa.

MOTHER
14. Maiden Name Madrig Penfield
15. Birthplace Philadelphia, Pa.

16 (a) Informant David P. Mulkay
(b) Address 4212 Penhurst Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 9-47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave

19 (a) (Date rec'd by registrar) (b) Thurlington for Williams M.D. Registrar

AUG 6. 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 6 1947, at 3:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-30 1947 to 8-6 1947, and that I last saw h.e.r alive on 8-6 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to Rheumatic heart disease, decompensated	
Due to	
Other Conditions Pos. post. pedestrinal Malignancy (Include pregnancy within 3 months of death)	

Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature William V. DeLuca M. D.
Address Md. Genl. Hosp. Date signed 8/6/47

G54081

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 516

G54081 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2515 Arbutus Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 2 2
(e) Length of stay in Baltimore (yrs., mos., or days) 7+ years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ~~Baltimore~~
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2515 Arbutus Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Brieber, Adolf Gustav

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married.

6 (b) Name of husband or wife Ida Henriette
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) 12. 2. 1870

8. AGE: Years	Months	Days	If less than one day
76	8	3	..... hr. ..... min.

9. Birthplace Germany Province Posen
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Brieber Ludwig
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Busse
15. Birthplace Germany

16 (a) Informant wife Mrs. Ida Henriette
(b) Address 2515 Arbutus Ave

17 (a) Burial (b) Date thereof Aug 8-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Emmanuel
Location Baltimore Md.

18 (a) Funeral director John C. Miller Inc
(b) Address 2435 E. Oliver St

19 (a) ..... (b) .....
(Date rec'd by registrar) Registrar

6 VS 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 5th 1947, at 9:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from October 19 1946 to Aug. 5th 1947, and that I last saw h. alive on Aug. 5th 1947.

Immediate cause of death Cancer of the prostrate gland — Duration .....
Due to ..... — .....
Due to ..... — .....
Other Conditions Generalized arteriosclerosis — .....
(Include pregnancy within 3 months of death)
Date of operation ..... — .....
Major findings of operation: ..... — .....
of autopsy: ..... — .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M.
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....
23. Signature Walther H. Sonnenfeldt M.D.
Address 2708 Hollins Ferry Rd Date signed 8/7/47

PLEASE WRITE PLAINLY, with ink. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

G54082 G54082

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 8913

PLEASE WRITE PLAINLY, WITH UNFADING INK. Burn correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital, Balto., Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 50 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Ga. (b) County
(c) City or town Brunswick
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2610 Albany St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Gilbert Monroe Martin

3 (b) If veteran, name war	3 (c) Social Security Account No. 178-18-9600

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mary Martin
6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) March 15, 1912

8. AGE: Years	Months	Days	If less than one day
35	4	22	hr. min.

9. Birthplace Brunswick, Ga.
(Town, county, and state)
10. Usual Occupation Chief Engineer
11. Industry or business Seafarer

FATHER
12. Name Charles Martin
13. Birthplace Leeco, Ga.

MOTHER
14. Maiden Name Julia Beaird
15. Birthplace Brunswick, Ga.

16 (a) Informant Records
(b) Address US Marine Hospital, Balto., Md.

17 (a) REMOVAL (b) Date thereof AUG 6 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory BRUNSWICK
Location BRUNSWICK, GA.

18 (a) Funeral director WILLIAM COOK FUN.
(b) Address 1217 ST. PAUL ST.
(c) (Date rec'd by registrar) Washington Williams (Registrar)

G B 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 1947, at 12:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1947, to Aug. 6 1947, and that I last saw him alive on Aug. 6 1947.

	Duration
Immediate cause of death Abscess, temporal lobe of brain, left side, inferior posterior portion.	3 months
Due to Mastoiditis, chronic, left.	3 months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surg. Clinical Director
Address US Marine Hospital, Balto., Md. Date signed 8/6/47

VS 180

G54083 BCH-84582 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 1579 G54083 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4954 Edgemere Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bruce Emil Small

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1947

8. AGE: Years	Months	Days	If less than one day
0	0	7	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Wm. L. Small
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Anna Hylla
15. Birthplace Balto. Md.

16 (a) Informant William L. Small
(b) Address 4954 Edgemere Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/6/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore City

18 (a) Funeral director L. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

19 (a) 1947 (Date rec'd by registrar) (b) Washington Williams, Registrar

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use only standard abbreviations. If exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-5-47 19 , at 3:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-4-47 19 , to 8-5-47 19 , and that I last saw h. liv. alive on 8-5-47 19 .

Immediate cause of death	Duration
Cardio Respiratory Failure	
Due to Intestinal Obstruction	
Due to Colitis - unknown etiology and Shock.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 8-4-47
Major findings of operation: Markedly Enlarged, thickened Colon
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Asher Friedman M. D.
Address Sinai Date signed 8-5-47

C54084

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

Registered No. C54084

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use only ink. Do not write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp. 11-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 906 Cathedral St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Adeline Haddon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 · 8 · 1874

8. AGE: Years	Months	Days	If less than one day
70	8	29	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Home keeper

11. Industry or business

FATHER
12. Name Calvin Hasson
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Weir
15. Birthplace Maryland

16 (a) Informant Harry H. Jackson (nephew)
(b) Address Pennsville - Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 9 1947 (month) (day) (year)
(c) Cemetery or crematory West Nottingham Cemetery
Location Oxford Cecil Co. Md.

18 (a) Funeral director Lee A. Patterson & Son
(b) Address Perryville, Md.

AUG 7 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 August 1947, at 8:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12 · 10 1946 to 8 · 6 1947 and that I last saw h[illegible] alive on 8 · 6 1947.

Immediate cause of death Uremia — Duration

Due to diabetic gangrene of left foot

Due to

Other Conditions Left leg amputated for diabetic gangrene (Include pregnancy within 3 months of death)

Date of operation 12 · 28 · 46

Major findings of operation: diabetes gangrene of left foot

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard G. Martin
Address Maryland Gen. Hosp. Date signed M. 8 · D. 6 · 47

G54085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

Registered No. G54085

PLEASE WRITE PLAINLY. Use ink. Do not use pencil. Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 924 Hanover St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 924 Hanover St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary V. Schroeder

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 6 1865

8. AGE: Years 81 | Months 8 | Days 4 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Louis Schroeder
13. Birthplace Germany

MOTHER
14. Maiden Name Hedwig Hoch
15. Birthplace Germany

16 (a) Informant Miss Amelia Schroeder (Sister)
(b) Address 924 Hanover St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Fri Aug 8 1947 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director A. Howard Evans
(b) Address 1400 N. Charles St.

AUG 7 1947 (Date rec'd by registrar) (b) Huntington Hillsinger M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Tues. Aug. 5 1947, at 7:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/3 1947 to Aug. 5 1947, and that I last saw her alive on 8/4 1947.

	Duration
Immediate cause of death: Coronary artery occlusion (arteriosclerotic)	3 days
Due to	
Due to	
Other Conditions: Hypertensive cardiovascular disease (Include pregnancy within 3 months of death)	2

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Weiss M. D.
Address 1126 Hanover St. Date signed 8/5/47

X

G54086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No. G54086

PLEASE WRITE PLAINLY, WITH INK. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1575 Abbotston St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1575 Abbotston St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret E. Downey

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) Feb 24th 1873

8. AGE: Years	Months	Days	If less than one day
74	5	12 10	hr. min.

9. Birthplace Balto, Md.
(Town, county, and state)
10. Usual Occupation Asst Principal
11. Industry or business

FATHER
12. Name John Downey
13. Birthplace

MOTHER
14. Maiden Name Joanna Slattery
15. Birthplace

16 (a) Informant Mrs. Mary E. Young
(b) Address 1575 Abbotston St.

17 (a) Burial (b) Date thereof 8/9/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location " Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (Date rec'd by reg.) AUG 7 1947 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6th 1947 at 11 45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1947 to Aug. 6 1947, and that I last saw h[illegible] alive on May 6 1947.

Immediate cause of death — Duration

Atero-Coronary Ischemia — 3 hrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation May 1 - 47

Major findings of operation: Duodenal ulcer, perforated by Roby. [illegible]

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Wm S Dehaut
Address 701 N. Kenwood Ave Date signed 8/6/47

G54087

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH ✓100a

G54087
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry must be complete and correct. Use black ink or typewriter. Do not use pencil. Do not write over or under lines. Be sure to write the causes of death clearly and legibly. Any false statement, omission, or concealment of the facts called for in this certificate is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 33 days
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 105 10th Ave Brooklyn Park
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nannie Goldsmith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	Married

6 (b) Name of husband or wife Jesse Goldsmith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-10-1891

8. AGE: Years	Months	Days	If less than one day
56	6	27	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business

FATHER
12. Name Charles W. Figge
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Minnie Cecil
15. Birthplace Maryland

16 (a) Informant Mrs. Jesse Goldsmith
(b) Address 105 10th Ave Brooklyn Park

17 (a) Burial (b) Date thereof 8/9/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cedar Hill
Location a.a. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 217 St Paul St

19 (a) AUG 7 1947 Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 August 1947, at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-4 1947 to 8-6 1947 and that I last saw h~~er~~ alive on 8-4 1947.

Immediate cause of death Conjestion + shock — Duration

Due to Complications of both leg amputation & left leg above knee

Due to Thrombosis of arteries (arterial occlusion)

Other Conditions Myocardial damage with fibrilations at times

Date of operation 7-5-47 + 8-2-47 (If not in 3 months of death)

Major findings of operation: Hemorrhaged

X Thrombosis of left femoral artery. Left gangrene of leg.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard E. Martin M. D.
Address Maryland Gen. Hosp. Date signed 8-6-47

G54088

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/3B

Registered No. G54088

PLEASE WRITE PLAINLY, with ink. Use no abbreviations. Give the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1231 Sargeant Street
(c) Hospital or institution: 21 → 2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1231 Sargeant Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louis Earl Davey

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	212-09-8457

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Lillian
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1902

8. AGE: Years	Months	Days	If less than one day
44	9	24	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Adjuster
11. Industry or business Coppers Co. Piston Ring D.

FATHER
12. Name William Davey
13. Birthplace Toronto, Canada

MOTHER
14. Maiden Name Grace Wheeler
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Lillian Davey
(b) Address 1231 Sargeant Street

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 8/8/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) AUG 7 1947 (Date rec'd by registrar) (b) Huntington Wells Burial Permit No.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6, 1947, at 3:30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/2/45 19 to 8/6 1947, and that I last saw h alive on 8/6 1947.

Immediate cause of death	Duration
Acute Cardiac Failure	1 da
Due to Bilateral Pulmonary	mp
Due to Tuberculosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Dept. Health Balto. MD
Address 1211 W. Lafayette Blvd. M. D.
Date signed 8/6/47

Wolters

G54089 BALTIMORE CITY HEALTH DEPARTMENT G54089
CERTIFICATE OF DEATH 194a Registered No.

PLEASE WRITE PLAINLY, with ink. Use no abbreviations. Be sure to write the causes of death clearly and correctly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 823 N. Port Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 823 N. Port Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John M. Wolters

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Wilhelmina C. Wolters
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21, 1859

8. AGE: Years 88 | Months 3 | Days 14 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Retired Lithographer

11. Industry or business

FATHER 12. Name Unknown Wolters
13. Birthplace Germany

MOTHER 14. Maiden Name Unknown Johnson
15. Birthplace Germany

16 (a) Informant Wilhelmina Wolters
(b) Address 823 N. Port Street

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 8/8/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) Filed by registrar AUG 7 1947 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5, 1947, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947 to August 3 1947 and that I last saw h alive on August 3 1947.

Immediate cause of death Coronary Thrombosis. — Duration about 4 weeks

Due to Arteriosclerosis. —

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hans Traupel
Address 1623 E. N. Ave. Date signed 8/6/47

Huntington Williams, M.D.

G54090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered No. G54090

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 235 N. Culver St.
(c) Hospital or institution: 20
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 235 N. Culver St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Claire M. Greene

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-07-7210

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Earl Livingston Greene
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 24, 1883

8. AGE: Years	Months	Days	If less than one day
53	10	11	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name James R. Orndorff
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Maude McIlhaney
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Robert E. Shreeve
(b) Address 235 N. Culver St.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof Aug. 7, 1947 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Baltimore, Md.

18 (a) Funeral director Wilbur L. Lemmon
(b) Address 4310 Liberty Heights Ave.

(a) Date received AUG 7 1947 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5 1947, at 3:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1945, to August 1947, and that I last saw her alive on August 5 1947.

Immediate cause of death Cerebral Vascular accident — Duration 1 day

Due to Arteriosclerosis — 1 yrs

Due to Hypertension — 2 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Francis W. Gluck M. D.
Address 3406 St Paul St Date signed 8/5/47

G54091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G54091

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon Secours Hosp
(c) Hospital or institution: 20-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 33da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 316 Mt. Olivet Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME mrs. clara R staff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	married

6 (b) Name of husband or wife August Staff
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Mar 6. 1896

8. AGE:	Years	Months	Days	If less than one day
	51	4 5	30	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name David Benton Shuler
13. Birthplace Carroll Co. Md

MOTHER
14. Maiden Name Clara Sheaffer
15. Birthplace Md

16 (a) Informant August Staff
(b) Address 316 Mt. Olivet Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 8 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Fredrick Ave

18 (a) Funeral director Mr & Mrs. John W. Gruber & Son
(b) Address 5311 Edmondson Ave

19 Aug 7 1947 (Date rec'd by reg.) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 1947, at 3:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 3 1947 to August 6 1947, and that I last saw her alive on August 6 1947.

Immediate cause of death Resp. failure due to Carcinoma of sigmoid accident — Duration

Due to

Due to

Other Conditions Diabetes, phlebo-thrombosis, Diverticulitis, gangrene of left leg (Include pregnancy within 3 months of death)

Date of operation August 4 1947 (Amputation Left leg)

Major findings of operation: Gangrene of left leg.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James A. Waddy M. D.
Address Bon Secour Hospital Date signed 8/8/47

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Statistical correct age is especially important.

54092

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 186a

Registered No. G54092

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital of inst. (yrs., mos., or days) 6 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2612 Erdmen Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Leroy George Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1931

8. AGE: Years	Months	Days	If less than one day
15	9 8	4	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name Charles W. Smith
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Loretta Milanick
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Loretta A. Smith
(b) Address 2612 Erdmen Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-9-47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore County, Md.

18 (a) Funeral director George A. Weber
(b) Address 745 S. Ann st.

19 AUG 7 1947 (Date rec'd by registrar) (c) Huntington Williams, M.D. Registrar

correct age is especially important. Physician: please w

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5 1947, at 9:55 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of neck
Contusion of spinal cord
Edema of lungs

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-29-47 at 8:35 P.M.
(b) Where did injury occur? Middle River
(c) Did injury occur at home, on farm, industrial place, in public place? Private place While at work? no
(d) Means of injury Dove into shallow water

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 8-6-47

VS 151

C54093
Z09868

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH (X 837)

Registered No. C54093

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Prince Georges
(c) City or town Laurel
(If outside city or town limits, write RURAL and give town)
(d) Street No. Laurel San.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Barker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-8-04

8. AGE: Years	Months	Days	If less than one day
42	7	23	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation none ?
11. Industry or business

FATHER
12. Name Dr. L. F. Barker
13. Birthplace Canada

MOTHER
14. Maiden Name L. Halsey
15. Birthplace La.

16. (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/7/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave. Balto. Md.
18 (a) Funeral director John O. Mitchell Inc.
(b) Address 1900 Eutaw Place
19 (a) AUG 7 1947 Received by registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 5 - 1947, at 4 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1- 1947, to 8-5- 1947 and that I last saw him alive on 8-5- 1947.

Immediate cause of death respiratory failure — Duration
Due to shock
Due to Acute Ch. Emphysema
Other Conditions Cerebral palsy
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton Gusack M. D.
Address J. H. H. Date signed 8-5-47

PLEASE WRITE PLAINLY, with ink. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G54094

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G54094

PLEASE WRITE PLAINLY. Use ink. Do not use pencil. Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1110 Hollins St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1110 Hollins St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John C. Peddicord
3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Katherine C.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 3rd 1879
8. AGE: Years 68 Months 2 Days 3 If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Self

FATHER
12. Name James Peddicord
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Gilland
15. Birthplace Md

16 (a) Informant Mrs. Evelyn M. Gammon
(b) Address 1110 Hollins St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/9/47 (month, day, year)
(c) Cemetery or crematory London Park Cem.
Location 3801 Frederick Rd.
18 (a) Funeral director John J. Gavanaugh Sons
(b) Address 901-03 Hollins St.
AUG 7 1947 (Date rec'd by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6th 1947, at 1:15 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1946, to Aug 5 1947 and that I last saw h[illegible] alive on Aug 5 19 1947

	Duration
Immediate cause of death: Acute Cardiac failure	2 days
Due to: Congestive failure	months
Due to: Arteriosclerotic heart disease	years
Other Conditions: Asthma	years

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Charles Tommaselo M. D.
Address 910 W. Lombard St Date signed 6 Aug. 1947.

V S 150

C54095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/64

Registered No. C54095

PLEASE WRITE PLAINLY, with ink. Physicians: please write the causes of death clearly and correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland Broadway & Fairmount

(b) Street address ~~Church Home~~

(c) Hospital or institution: CHURCH Home + Hosp. 27

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County

(c) City or town BALTO. (If outside city or town limits, write RURAL and give town)

(d) Street No. 12 HOMELAND Ave (If rural give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3 (a) FULL NAME Hughes, BABY Boy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 6 - 1947

8. AGE: Years 0 | Months 0 | Days | If less than one day 10 hr. 5 min.

9. Birthplace BALTO, Md. (Town, county, and state)

10. Usual Occupation BABY

11. Industry or business

FATHER 12. Name FREDRICK Hughes

13. Birthplace MARYland.

MOTHER 14. Maiden Name Sylvia SHIELD

15. Birthplace MARYLAND

16 (a) Informant Sylvia Hughes

(b) Address 12 HOMELAND Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/7/47 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Eastern Ave. Rd.

18 (a) Funeral director John P Connelly

(b) Address 418 Eastern Ave Balto

AUG 7 1947 (Date rec'd by registrar) (Huntington Williams, M.D.) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/5 1947, at 3.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/5 1947 to 8/5 1947 and that I last saw him alive on 8/5 1947.

Immediate cause of death	Duration
Respiratory FAILURE	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None.

Major findings of operation:

of autopsy: ENLARGED Thymus

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature George W Worth

Address 5900 Church Home Date signed 8/7/47 M. D.

X

C54096 LW-11,695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓186a

Registered No. C54096

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 17-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
532 W. Lafayette St.
(d) Street No. 7275 Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Dorsey

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 55 ? | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-7-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 AUG 7 1947 (Rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 2- 1947, at 11:p M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-3 19 47 to 8-2 19 47, and that I last saw him alive on Aug. 2 19 47.

Immediate cause of death	Duration
Malnutrition	
Due to Seizure loss through descubitus ulcer	
Due to Spinal cord injury following fall.	2 wks.
Other Conditions Terminal Pneumonia	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operations —
of autopsy Displaced disc at C-4-5

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 17/1
(a) Accident, suicide, or homicide accident
(b) Date of occurrence ? June 1947 ? M
(c) Where did injury occur? 7275 S. Charles St. Balt. City Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home While at work? no
(Specify type of place)
(e) Means of injury Fell from stairs

23. Signature R. T. Bamford, M. D.
Address Balt. City Hosp. Date signed 8-4-47

VS 150 To Be Approved By Medical Examiner Howard J. Mendelsohn, M.D. X

PLEASE WRITE PLAINLY, in ink or indelible pencil. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

C54097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

A 53677 · 303 / 47 F

Registered No. C54097

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 27 E Ship Rd (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Ronald Thomas Bradley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-14-1939

8. AGE: Years	Months	Days	If less than one day
8	5	20	..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER
12. Name Francis Bradley
13. Birthplace Md.

MOTHER
14. Maiden Name Hilda Monti
15. Birthplace Pa.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial [illegible] (Burial, cremation, or removal) (b) Date thereof 8-9 47 (month) (day) (year)
(c) Cemetery or crematory Ridgely Redeemer
Location Belair Road

18 (a) Funeral director Frederick D Miller, Inc
(b) Address 3096 Monument St

AUG 7 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

PLEASE WRITE PLAINLY. Use ink. Do not use pencil. Please write the causes of death clearly and legibly. Be sure to correct age is especially important. Physicians: please write

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug-6 1947, at 6 50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-4- 1947 to 8-6- 1947 and that I last saw him alive on 8-6- 1947

Immediate cause of death RESPIRATORY FAILURE — Duration .....

Due to MEDIASTINAL LYMPHOSARCOMA — Duration .....

Due to ..... — Duration .....

Other Conditions ..... — Duration .....

(Include pregnancy within 3 months of death)

Date of operation MAY - 1947.

Major findings of operation: SAME

of autopsy: SAME

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature William A. Spencer

Address Johns Hopkins Hosp Date signed 8/6/47

Harriet Lane Home. X

G54098

LW 112741

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G54098

PLEASE WRITE PLAINLY, in ink. Physicians: please write the causes of death clearly and legibly. Be sure that correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da.
(e) Length of stay in Baltimore (yrs., mos., or days) lifers.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 27 N. Carey St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Louise Walter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Seperated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1885

8. AGE: Years 61 | Months 9 | Days 3 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Peter Glos
13. Birthplace Md.

MOTHER
14. Maiden Name Hannah Otto
15. Birthplace Md.

16 (a) Informant Records Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 9. (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 1917 E. Oliver St.

19 AUG 7 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 6 19 47 at 12:31 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 5 19 47, to Aug. 6 19 47 and that I last saw her alive on Aug. 6 19 47.

	Duration
Immediate cause of death: Shock due to Hemorrhage	1 day
Due Adenocarcinoma of Uterus	1½ years
Due to Intertrochanteric fract of Left Femur	1 day
Other Conditions (Include pregnancy within 3 months of death)	

Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 8-4-47 at 7 P.M.
(c) Where did injury occur? Nursing Home Baltimore
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Nursing Home While at work? No
(Specify type of place)
(e) Means of injury Fall

23. Signature A. Butler
Address City Hosp. Date signed 8-7-47 M.D.

VS 150

To Be Approved BY Medical Examiner G. G. Merrill M.D.

G54099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G54099

PLEASE WRITE PLAINLY, with unfading ink. Fill in all items. Give the causes of death clearly and legibly. Use only standard abbreviations. Be sure that the correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1911 E. 20th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1911 E. 20th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Giuseppe Maranto

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of ~~husband or~~ wife late Theresa Maranto
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 10-1861

8. AGE: Years	Months	Days	If less than one day
86	2	26	hr. min.

9. Birthplace Ceda lu Palermo Italy
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Antonio Maranto
13. Birthplace Italy

MOTHER
14. Maiden Name Angelina Barranco
15. Birthplace Italy

16 (a) Informant ANGELINA MARANTO
(b) Address 1911 E. NORTH AVE

17 (a) Burial (b) Date thereof August 9 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Bolair Rd. Baltimore Md.
18 (a) Funeral director Frank Della Rocca
(b) Address 52 N Varley St.
19 (a) (b) Huntington Williams Mortuary
(Date rec'd by registrar) Registrar

AUG 7 - 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1947 at 11:45 P M
21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947 to Aug 6 1947
and that I last saw him alive on Aug 5 1947.
Immediate cause of death Cardiac Failure — Duration
Due to Arteriosclerotic Cardio-Vascular disease. —
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. R. Stevens
Address 3408 Edmondson Ave Date signed 8/6/47

G54100
GM 112708

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G54100 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Essex Balto. CO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 315 Candry Terrace Z 21
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Stresser Mentzer

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-22-5058

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Myra
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4 - 1903

8. AGE: Years	Months	Days	If less than one day
43	10	2	hr. min.

9. Birthplace Penna. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Lincoln Mentzer
13. Birthplace Penna.

MOTHER
14. Maiden Name Minnie Stresser
15. Birthplace Penna.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern AVE.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8-7 47 (month) (day) (year)
(c) Cemetery or crematory
Location Mapleswing Penna

18 (a) Funeral director Brudzinsky
(b) Address 1707 Eastern Ave Rd

19 (a) (Date received by registrar) (b) Huntington Williams, M.D.

VS 150 To Be Approved By Medical Examiner

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. - 6 - 1947 6.30A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 3 - 1947 to Aug. 6 - 1947 and that I last saw him alive on Aug. 6 - 1947.

Immediate cause of death	Duration
Cerebral Edema	
Due to Acute Alcoholism;	
Due to	
Other Conditions Chronic Alcoholism; Delirium tremens	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy Cerebral Edema

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edw. D. Sheparovych M. D.
Address Balto. City Hosp. Date signed 8-6-47

Howard J. Tenney, M.D.

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and correct age is especially important.

C54101 BALTIMORE CITY HEALTH DEPARTMENT C54101
Registered No.

CERTIFICATE OF DEATH 1937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2316 E. North Ave.
(c) Hospital or institution: 8 & 2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2316 E. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARTHA MAUDE ALEXANDER

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Chas. S. Alexander
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1875

8. AGE: Years	Months	Days	If less than one day
71	10	5	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Jacob Taylor
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Sarah Burton
15. Birthplace Balto. Md.

16 (a) Informant Mr. Robert Alexander
(b) Address 2629 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/9/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC
(b) Address North & Pa. Aves. Balto. 17. Md.

19 (a) Huntington Williams, M.D. (Registrar)
(b) Date received AUG 7 1947 Registrar

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and accurately. Correct age is especially important.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 5 1947 19 , at 9.15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 29 1947 to Aug. 5 1947. and that I last saw her alive on Aug 5 1947.

Immediate cause of death	Duration
Coronary Thrombosis	1 week
Due to Hypertension - Arteriosclerotic Heart Disease	?
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature Wilbur H. Fusting M.D.
Address 11 E. Chase St. Date signed 8-6-47

X

G54102 Freze G54102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 171a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 219 Detroit Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Fryza Freze

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 16, 1880

8. AGE: Years 66 | Months 11 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Frank Cybulski

13. Birthplace Grudziady Poland

MOTHER 14. Maiden Name Teofilia Ticholska

15. Birthplace Grudziady, Poland

16 (a) Informant Mrs. Regina Brockman

(b) Address 359 Foltz St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/9/47 (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus

Location Mt. Carmel Road

18 (a) Funeral director M. J. Dubowski Sons

(b) Address 1808 Eastern Avenue

(c) AUG 7 - 1947 (Date rec'd by registrar) Huntington Williams Mar. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-5 1947, at 2:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Subarachnoid hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-3-47 at 3:45 a. M.
(b) Where did injury occur? Dundalk - Linwood Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? no
(d) Means of injury Ped. struck by automobile

23. Signature [signature] M.D. (Medical Examiner)

Date signed 8-6-47

Correct age is especially important. Physicians: please write plainly.

G54103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G54103

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 605 N. Kenwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 605 N. Kenwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret E. Bridges

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Jno. H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24-1875

8. AGE: Years 72 | Months 2 | Days 12 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Julius Praetorius

13. Birthplace France

MOTHER 14. Maiden Name Madeline Sadler

15. Birthplace Balto. Md.

16 (a) Informant Dr. W. Connelly

(b) Address 605 N. Kenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/8/47 (mo.) (day) (year)

(c) Cemetery or crematory Mem. Gdns.

Location Old Frederick Rd.

18 (a) Funeral director John A. McShane

(b) Address Home Balto. Md.

19 (a) AUG 7 - 1947 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and report correct age is especially important.

V S 150

MEDICAL CERTIFICATION P.

20. DATE OF DEATH Aug. 5 1947, at 2:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 12, 1946, to Aug. 5, 1947, and that I last saw her alive on Aug. 5, 1947

Immediate cause of death: Cerebral Hemorrhage — Duration: 6 days

Due to: Cardiovascular Renal Disease (arteriosclerotic) — Duration: Unknown

Due to:

Other Conditions: (Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Philbert Artigiani

Address 2942 E. Fayette St. Date signed 8/6/47

X

54104 Kennard.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1061B

Registered No. 054101

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Use only standard abbreviations. Do not use ditto marks. Be sure that the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3046 Guilford Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3046 Guilford Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

2 (a) **FULL NAME** Caroline Barney Wickes Kennard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1863

8. AGE: Years	Months	Days	If less than one day
83	10	7	hr. min.

9. Birthplace Chestertown, Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Judge Joseph A. Wickes
13. Birthplace Kent Co., Md.

MOTHER
14. Maiden Name Anna Maria Tilghman
15. Birthplace Queen'Anne's Co., Md.

16 (a) Informant Mrs. Adelaide G. Robinson
(b) Address 3046 Guilford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/8/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem
Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell Sons
(b) Address Orange Extension

AUG 7 - 1947 (Date rec'd by registrar) (b) Huntington Williams M. D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 August 1947, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 Aug 1947 to 6 Aug 1947 and that I last saw h.e. alive on 6 Aug 1947

Immediate cause of death	Duration
bronchitis chronic	1944
Due to	
Due to Paralysis agitans	1933
Other Conditions Fracture hip	1941

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation none
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard R. Smith, Jr. M. D.
Address 1614 St Paul St. Date signed 6 Aug, 47.

54105

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G54105

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3114 Hudson Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3114 Hudson Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Michael Schwartz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced M.

6 (b) Name of husband or wife PAULINE E. LABER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 23-1883

8. AGE: Years 64 | Months 6 | Days 13 | If less than one day 12 hr. min.

9. Birthplace BALTIMORE, MARYLAND (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John Schwartz
13. Birthplace GERMANY

MOTHER
14. Maiden Name MARY NITZEL
15. Birthplace GERMANY

16 (a) Informant MRS. Pauline Schwartz (WIFE)
(b) Address 3114 Hudson STREET

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-8-47 (month) (day) (year)
(c) Cemetery or crematory OAKLAWN CEMT
Location 6425 EASTERN AVE

18 (a) Funeral director CLARENCE F. HOFFMANN
(b) Address 1639 North BROADWAY

19 AUG 7 - 1947 (b) Huntington for Williams, M.D. Registrar

correct age is especially important. Physicians, please write plainly.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/4/47 19..., at 11:55 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D. Medical Examiner.
Date signed 8/5/47

X

G54106 BALTIMORE CITY HEALTH DEPARTMENT G54106

CERTIFICATE OF DEATH 55E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital, Balto., Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 45 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Texas (b) County
(c) City or town San Antonio
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1330 Brighton Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond de los Santos

3 (b) If veteran, name war

3 (c) Social Security Account No. 466-10-8102

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Lucy Sanchez DeLosSantos

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3, 1901

8. AGE: 46 | Years 45 | Months 4 | Days 2 | If less than one day hr. min.

9. Birthplace San Antonio, Texas
(Town, county, and state)

10. Usual Occupation Master

11. Industry or business Seafarer

FATHER
12. Name Vicente De Los Santos
13. Birthplace Medina Co., Texas

MOTHER
14. Maiden Name Antonia Rojas
15. Birthplace Mexico

16 (a) Informant Records
(b) Address U.S.Marine Hospital,Balto.,Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug 7-47 (month) (day) (year).
(c) Cemetery or crematory San Antonio Texas
Location Texas

18 (a) Funeral director Williams Coth Inc
(b) Address 1217 St Paul St

19 (a) AUG 7 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Please state correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5 1947, at 5:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 21 1947 to Aug. 5 1947 that I last saw him alive on Aug. 5 1947

Immediate cause of death Pericardium Cert Tamponade — Duration

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address U.S. Marine Hosp Balto Md Date signed 8-6-47

VS 180

STALLINGS

54107

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 H

Registrar's No. 54107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1604 E Biddle St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1604 E Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Stallings

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C.	Married

6 (b) Name of husband or wife Annie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2, 1891

8. AGE: Years	Months	Days	If less than one day
56	1	4	hr. min.

9. Birthplace New Orleans (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Kit Stallings
13. Birthplace New Orleans

MOTHER
14. Maiden Name Rachel
15. Birthplace New Orleans

16 (a) Informant Annie Stallings
(b) Address 1604 E Biddle St

17 (a) Removal (b) Date thereof Aug 10/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Matthews County Va

18 (a) Funeral director Mrs. Pott D. Elliott
(b) Address 1129 N. Carlisle St

19 (a) AUG 7 1947 (b) Washington Willis Russell Jr

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-6 1947 at 10 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1947 to 19 and that I last saw him alive on July 15, 1947.

Immediate cause of death	Duration
Mesenteric carcinomatosis with metastasis	
Due to the lungs and	
epillary glands	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. R. Campbell M. D.
Address 718 Dolphin St. Date signed 8-7-47
Howard J. Sheeran, M.D.

PLEASE WRITE PLAINLY. Physicians: please write the cause of death clearly and correctly. Correct age is especially important.

G54108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94B

Registered No. G54108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1414 Battery Ave
(c) Hospital or institution: 24-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1414 Battery Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie May

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed.

6 (b) Name of husband or wife Michael

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12- 1881

8. AGE: Years 65 | Months 9 | Days 24 | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Patrick Moon
13. Birthplace Ireland

MOTHER 14. Maiden Name ?
15. Birthplace

16 (a) Informant Michael J. May
(b) Address 1414 Battery Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-9-1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 (a) AUG 7 - 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 5 - 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 31 1947 to Aug 5 1947 and that I last saw h[illegible] alive on Aug 5 1947

Immediate cause of death Angina Pectoris — Duration 3 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Wheeler
Address 1279 Fulham Ave Date signed 8/7/47 (M. D.)

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

VS 150

54109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

Registered No. G54109

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard + Greene Streets
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore - Parkville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2906 Onyx Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Coleman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Harry R.
6 (c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1921

8. AGE: Years	Months	Days	If less than one day
25	7	10	hr. min.

9. Birthplace Stewart, Mississippi
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name De Witt Mitchell
13. Birthplace Mississippi

MOTHER
14. Maiden Name Ruby Pearson
15. Birthplace Mississippi

16 (a) Informant Harry R. Coleman
(b) Address 2906 Onyx Rd, Parkville

17 (a) removal (b) Date thereof 8/8/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Williams Funeral Home
Location Hanover, Mississippi

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 201 St. Paul St.

19 (a) Date received AUG 7 1947 (b) Thurlington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 1947, at 3:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 2 1947 to Aug. 7 1947 and that I last saw h[illegible] alive on Aug. 7 1947.

Immediate cause of death	Duration
Cerebral edema and Respiratory Collapse	
Due to Acute lymphatic leukemia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sidney N. Coates
Address Univ. Hosp. Date signed 8/7/47

PLEASE WRITE PLAINLY. Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

X

G54110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G54110

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1014 N. Dallas St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1014 N. Dallas St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Mayden

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4 1883

8. AGE: Years	Months	Days	If less than one day
62	1	2	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Richard Mayden Sr
13. Birthplace Va

MOTHER
14. Maiden Name Catherine Brown
15. Birthplace Va

16 (a) Informant Geraldine Williams
(b) Address 1014 N. Dallas St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 9. 47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co.

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 AUG 7 1947 (Date rec'd by registrar) (b) Huntington Williams Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6 1947, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1947 to Aug 6 1947, and that I last saw h— alive on Aug 6 1947.

Immediate cause of death
Uremia Hypertension

Due to Chr. Cardio - renal vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration: 1 day, 7

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. L. Perry M. D.
Address 1920 E. Chase Date signed 8-7-47

X

Please write clearly and use ink. Physicians: please write the cause of death clearly and correct age is especially important.

G54111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V94a

G54111 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1812 E. Chase St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1812 E. Chase St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John R. STOKES

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 22-1899

8. AGE: Years	Months	Days	If less than one day
47	10.	12	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation General Contractor
11. Industry or business

FATHER
12. Name Ruben Stokes
13. Birthplace Va

MOTHER
14. Maiden Name Unknown
15. Birthplace Va

16 (a) Informant Mrs Virginia Stokes
(b) Address 1812 E Chase St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-8-47 (month) (day) (year)
(c) Cemetery or crematory U.S. Balto National Cem
Location Balto

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4 1947, at 9:35 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Coronary Artery disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 8/4/47

X

G54112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓16

G54112
Registered No.

CM. 110974

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Months
(e) Length of stay in Baltimore (yrs., mos., or days) 18 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 507 N. Bond ST. Z 5
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Sheppard

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June -22 - 1907

8. AGE: Years	Months	Days	If less than one day
40	1	15	14 hr. min.

9, Birthplace VA.
(Town, county, and state)
10. Usual Occupation Book Keeper
11. Industry or business

FATHER
12. Name Robert Sheppard
13. Birthplace VA.

MOTHER
14. Maiden Name Selena Totein
15. Birthplace VA.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern AVE.

17 (a) Shipped (b) Date thereof 8/9/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Portsmouth
Location Virginia
18 (a) Funeral director Cupper Sanders
(b) Address 1412 E. Preston St.
19 AUG 7 - 194 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 6 - 1947 at 6.20A M

21. I certify that death occurred on the date above stated; that I attended deceased from May - 27 1947 to Aug 6 - 1947
and that I last saw h or alive on Aug. 6 - 1947

Immediate cause of death	Duration
Cardiac arrest	
Due to Myocardial atrophy -	
Due to Disseminated Lupus erythematosis.	
Other Conditions Tuberculous mesenteric adenitis & pneumothorax	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: On chart.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature William H. Vinton Jr. M.D.
Address Balto City Hosp. Date signed Aug 10

VS 150

Please write the causes of death very plainly. Physicians: please write correct age is especially important.

G54113 G54113

BALTIMORE CITY HEALTH DEPARTMENT

BC# F 47943 CERTIFICATE OF DEATH 14

Registered No.

PLEASE WRITE PLAINLY, with ink. Make the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1101 Patapsco Ave (If rural give location)
(e) Citizen of foreign country? no Brooklyn (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Matuszewski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20, 1942

8. AGE: Years 5 | Months 3 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER 12. Name Frank Matuszewski
13. Birthplace Maryland

MOTHER 14. Maiden Name Etta M Rolle
15. Birthplace Md

16 (a) Informant Mrs Etta Matuszewski
(b) Address 1101 Patapsco Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Mea Loy Ridge Mem
Location Nursery Cor. Washington Blvd

18 (a) Funeral director L. L. Hesp
(b) Address 715 Light Street

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

AUG 1950 - 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5 1947, at 7 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 3 1947, to Aug 5 1947, and that I last saw h[illegible] alive on Aug 5 1947

Immediate cause of death: Tuberculous meningitis — Duration 6 mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Confirmatory

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Dillon M. D.

Address South Balto Gen. Hosp Date signed Aug 6

X

G54114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

G54114 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2001 W. Fayette St.
(c) Hospital or institution: Bon Secours 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1934 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Irene H. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~.

6 (b) Name of husband ~~or wife~~ Raymond Irvin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 30, 1888

8. AGE: Years 58 | Months 9 | Days 8 | If less than one day hr. min.

9. Birthplace Ohio
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Smith
13. Birthplace England

MOTHER
14. Maiden Name Martha Deaton
15. Birthplace England

16 (a) Informant Mrs. Shelly
(b) Address Mansfield Ohio.

17 (a) Removal (b) Date thereof 8-7-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Mansfield Ohio

18 (a) Funeral director George A Farley
(b) Address Fulton and Fayette St

AUG 7 - 1947
(Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 1947, at 4:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 19..., to 19..., and that I last saw h~~er~~ alive on August 7 1947.

Immediate cause of death	Duration
Cardiac Decompensation	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul R Massmo. M. D.
Address Dan Lenoure Hosp. Date signed 8/7/47

VS 150

X

G51115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G51115 Registered No. 12 a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4404 Adelle Terrace
(c) Hospital or institution: ~~4404~~ Adelle Terrace
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4404 Adelle Terrace
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Roman C. Nitsch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Loretta L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22, 1873

8. AGE: Years	Months	Days	If less than one day
74	4	14	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Charles F.
13. Birthplace Germany

MOTHER
14. Maiden Name Josephine Sweat
15. Birthplace Germany

16 (a) Informant Joseph Nitsch
(b) Address ~~4404~~ Catonsville, Md.

17 (a) Burial (b) Date thereof 8-8-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director George A Fooley
(b) Address Fulton Ave - Forty Hoe St

19 (a) AUG 7 1947 (b)
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5 1947, at 3.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 28 1947, to Aug 5 1947, and that I last saw him alive on Aug 5 1947.

Immediate cause of death	Duration
Pulmonary Oedema	
Hypostatic pneumonia	
Due to Arteriosclerosis	
Due to Chronic Nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Huntington Williams M.D.
Address 2151 - W Lexington St Date signed 8/6/47

PLEASE WRITE PLAINLY. Write the causes of death clearly and legibly. Correct age is especially important. Physicians: please write the

X.

116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. 54116

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3404 St. Paul Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3404 St. Paul Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Elizabeth Jacobs

3 (b) If veteran, name war
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Milton Henry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28, 1877

8. AGE: Years	Months	Days	If less than one day
70	1	9	hr. min.

9. Birthplace York County, Pennsylvania (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jacob Harbolt
13. Birthplace York County, Pennsylvania

MOTHER
14. Maiden Name Sarah Cook
15. Birthplace York County, Pennsylvania

16 (a) Informant Miss Mary L. Jacobs
(b) Address 3404 St. Paul Street

17 (a) removal (Burial, cremation, or removal) (b) Date thereof 8/9/47 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location York, Pennsylvania

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

AUG 8 - 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7, 1947, at 1:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 16 1947, to August 7 1947 and that I last saw her alive on August 7 1947.

Immediate cause of death Cardio-Renal Failure — Duration

Due to Hypostatic Pneumonia

Due to

Other Conditions Carc. uterus, stomach with Metastasis

(Include pregnancy within 3 months of death)

Date of operation May 12, 1942

Major findings of operation: Metastatic Carcinoma (St. mach, liver etc.)

of autopsy

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Neuland Edward Day M. D.

Address 4-E-33rd St Balto 18 Date signed Aug 8 1947

X

Please write the causes of death clearly and correct age is especially important. Physicians: please write

117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157a

Registered No. G54117

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 1
(e) Length of stay in Baltimore (yrs., mos., or days): 1

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: Baltimore
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 296 Edgewater Apts.
(If rural give location (Rural Route))
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: Baby de Mena

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days: 0 | If less than one day: 13 hr. 45 min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business:

FATHER
12. Name: Russell H. de Mena
13. Birthplace: Darlington, Md.

MOTHER
14. Maiden Name: Gertrude A. Meyers
15. Birthplace: Baltimore, Md.

16 (a) Informant: Gertrude A. deMena
(b) Address: 296 Edgewater Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/9/47 (month) (day) (year)

(c) Cemetery ~~or crematory~~: Parkwood
Location: Parkville, Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 217 St. Paul St.

AUG 8 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 6, 1947 at 5:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 2, 1947, to Aug 6, 1947 and that I last saw him alive on Aug 6, 1947

Immediate cause of death: Respiratory Failure — Duration:

Due to: Hydrocephalus

Due to: Spina Bifida + Meningocoele

Other Conditions: Club Feet, Bilateral

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy: Hydrocephalus, Spina Bifida, Club Feet

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Anthony F. DiPaula M.D.

Address: St. Joseph's Hosp. Date signed 8/8/47

X

Please write the cause of death clearly and legibly. Physicians: please write correct age is especially important.

54118 G54118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. 8th
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2006 E. Biddle st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jerome Hamilton

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Barbara Cummings
(b) Address 1006 Biddle St Br 9016

17 (a) Burial (b) Date thereof 8/8/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto.
Location " Md.

18 (a) Funeral director Williams Cook Inc
(b) Address 127 St. Paul st
(c) 8 - 1947 Huntington Williams, Mgr.
(Date rec'd by registrar)

VS 191

correct age is especially important

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/5 1947, at 8 3. A.M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrell M.D.
Medical Examiner.
Date signed 8/5/47

1119 Dr. Jones

BALTIMORE CITY HEALTH DEPARTMENT ✓ G54119

CERTIFICATE OF DEATH 131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 885 Tyson St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 885 Tyson Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jerry Baker

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Colored	married

6 (b) Name of husband or wife Eunice
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1887

8. AGE: Years	Months	Days	If less than one day
59	10		hr. min.

9. Birthplace Georgia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Jerry Baker, Sr.
13. Birthplace Georgia

MOTHER
14. Maiden Name Eva Gragg
15. Birthplace Georgia

16 (a) Informant Eunice Baker
(b) Address 885 Tyson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/8/47 (month) (day) (year)
(c) Cemetery or crematory Griffin
Location Georgia

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) AUG 9 1947 (State registrar) (b) Issued by Wellington Williams, M.D.

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Statements of time, date and place must be correct age is especially important.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 6, 1947, at 4 40 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1947, to Aug. 6 1947, and that I last saw him alive on Aug. 5 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension - Senile	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Wellington Williams
Address 1308 N. Gilmor Date signed 8/6/47

X

1120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 61

G51120 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3725 Edmondson Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3725 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles F. Klein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Caroline Pailer Klein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 28, 1878.

8. AGE: Years	Months	Days	If less than one day
68	11	9 10	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Carl Klein
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Klein
15. Birthplace Md.

16 (a) Informant Caroline P. Klein
(b) Address 3725 Edmondson Ave.

17 (a) Burial (b) Date thereof Aug. 9/47.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave. & Longwood St.

18 (a) Funeral director Harry H. Sutfel
(b) Address 4101 Edmondson Ave.

19 (a) AUG 8 - 1947 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 7/47. 19 , at 20. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 6 1947 to Aug 7 1947, and that I last saw h[illegible] alive on Aug 6 1947

Immediate cause of death	Duration
Arteriosclerotic Cerebro-Vascular Disease	5 yrs
Due to	
Due to	
Other Conditions Diabetes Mellitus	10 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Albert J. Bischof M. D.
Address 2302 Edmondson Ave Date signed 8/8/47

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Statement of age is especially important.

VS 156

83a

54121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G54121 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3907 Pinkney Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3907 Pinkney Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH PIVEN

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 56 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-8-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Park Hts & Hamilton Ave

18 (a) Funeral director Sol Levin Inc
(b) Address 2100 Eutaw Place

19 AUG 8 - 1947 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-7-47 19 , at 6 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 5, 1947 to Aug 7 1947 and that I last saw him alive on Aug 7, 1947.

	Duration
Immediate cause of death: Cerebral Hemorrhage	2 days
Due to: Progressive Vascular degeneration	over 2 yrs.
Due to:	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Abram Goldman M.D.
Address 3834 Park Hts. Ave Date signed 8/8/47

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Be sure the correct age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

Registered No. G54122

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rutland + Monument
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2203 Orleans St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Denie Karlin also DINE KARLIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 56 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Nathan
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah
15. Birthplace Russia

16 (a) Informant Harry Nechamkin
(b) Address 104 N Front St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-8-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd + Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 200 Eutaw Place

AUG 8 - 1947 (Date rec'd by registrar) Hamilton for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/7 1947 at 6 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 28 1947 to 8/7 1947 and that I last saw h er alive on 8/7 1947

Immediate cause of death: Pulmonary edema — Duration: 3 days

Due to: Chronic myelogenous leukemia — 3 yrs

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: Myelogenous leukemia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ben Cohenberg

Address Sinai Hosp Date signed M. 8 D. 7 47

X

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G54123

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2601 Roslyn Ave.,
(c) Hospital or institution:
Kenesaw Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5209 Linden Heights Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Otto John Gohr

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Bertha Gohr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 3, 1860

8. AGE: Years 86 | Months 8 | Days 3 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Germany

16 (a) Informant Mrs. Carrie D. Coleman
(b) Address 5209 Linden Heights Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-9-47 (month) (day) (year)
(c) Cemetery or crematory Salem Lutheran
Location Catonsville, Md.

18 (a) Funeral director H. Howard Strong
(b) Address 3207 W. North Ave.

AUG 8 - 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 1947 at 9.30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/17/47 19 , to 8/ 6/47 19 , and that I last saw him alive on 8/5/47 19 .

Immediate cause of death: Pulmonary Edema — Duration: 1 day

Due to: Chr. Cardio vascular disease — ?

Due to: Fracture of right hip — since 6/17/47

Other Conditions: Senility

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident 27/18
(b) Date of occurrence 6/17/47 at M
(c) Where did injury occur? 5209 Linden Hgts Ave (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fall down stone

23. Signature Geo. G. Merrill M.D.
Address 1901 Eutaw Place, City Date signed 8/8/47

Geo G. Merrill MD

VS 150

PLEASE write plainly with pen or pencil. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G51121
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 Chapelgate Lane
(c) Hospital or institution: Pinecrest Sanatorium
(d) Length of stay in hospital or inst. (yrs., mos., or days) since 7/9/47
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Sp. Pt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2602 Sp. Pt. Rd.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mustaxine Constans

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) ~~Single, married~~, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years 81 | Months | Days | If less than one day hr. min.

9. Birthplace Greece
(Town, county, and state)

10. Usual Occupation House wife
11. Industry or business

FATHER 12. Name Unknown
13. Birthplace "

MOTHER 14. Maiden Name "
15. Birthplace "

16 (a) Informant Nick Tsumbos
(b) Address 2602 Sp. Pt. Rd.

17 (a) Burial (b) Date thereof 8-8-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Annapolis Road

18 (a) Funeral director John G. Connelly
(b) Address 918 Eastern Ave. Balto 31 Md.

19 (a) AUG 8 1947 (b) Huntington White
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/6 1947, at 1:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/19 1945, to 8/6 1947 and that I last saw h alive on 8/6 1947

Immediate cause of death Coronary Occlusion — Duration 3 days
Due to Arteriosclerosis
Due to
Other Conditions General Arteriosclerosis — 1
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature S. P. Agapes M. D.
Address 33 Washington Blvd signed

PLEASE WRITE PLAINLY; please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

139B

Registered No. G54125

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 14
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 605 Pitcher St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Grace Westcott

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife William B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1-17-73

8. AGE: Years	Months	Days	If less than one day
74	6	18	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Isaac Richardson
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Jackson
15. Birthplace Md.

16 (a) Informant Mrs. Edwin Westcott
(b) Address 2078 N. Charles Ave.

17 (a) Burial (b) Date thereof Aug. 9, 19 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Balto. Co. Md.

18 (a) Funeral director Chas. H. Holland
(b) Address 1631 Druid Hill Ave.

19 AUG 8 - 1947 (b) Hunter Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5 19 47 at 1 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1947 to Aug 5 1947, and that I last saw her alive on Aug 5 19 47.

Immediate cause of death Coronary Thrombosis — Duration

Due to Unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7/30/47

Major findings of operation: Prolapse of uterus

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature E. W. Mitchell Jr.
Address Johns Hopkins Hosp. Date signed 8/6/47

X

Please write the correct age is especially important. Physicians: please write the

51-126 D.o.d. BC #85582

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

Registered No. C51126 G-54126

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 733 Wilmer Ct
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Baby Boy Haskins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 8-8-47

8. AGE: Years	Months	Days	If less than one day
			7 hr. 5 min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER
12. Name William Horne
13. Birthplace N. C.

MOTHER
14. Maiden Name Lillian Haskins
15. Birthplace N. C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a)..... (b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory.....
Location.....

18 (a) Funeral director.....

(b) Address.....

AUG 15 1947
(Date rec'd by registrar)

Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-8-47 at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....; and that I last saw h..... alive on ..... 19.....

Immediate cause of death Bronchopneumonia

Due to.....

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature A. Edmonds

Address Johns Hopkins Date signed 8-[illegible]-47

Physicians: please write correct age is especially important.

Johns Hopkins Medical School AUG 14 1947

Commissioner of Health

127.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G54127.
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1817 N. Monroe St.
(c) Hospital or institution:
15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1817 N. Monroe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FREDERICK ADRIAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Christina Adrian
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28, 1873

8. AGE: Years	Months	Days	If less than one day
74	2	8	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Linotype Operator
11. Industry or business Sun Papers.

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Maurice Brophy
(b) Address 1817 N. Monroe St.

17 (a) Burial (b) Date thereof 8/9.47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC
(b) Address North & Pa. Aves. Balto. 17, Md.

19 AUG 8 - 1947 (b) Huntington Williams M.D.
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 6, 1947 19 , at 5:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1, 1947 to Aug. 8, 1947 and that I last saw him alive on Aug. 6, 1947.

Immediate cause of death Carcinoma of Ascending Colon — Duration

Due to Metastatic Carcinoma of Liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Maurice Brophy
Address 133 E. Northave Date signed 8-7-47

X

Physician: please write plainly in ink. Be sure correct age is especially important.

128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G54128

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1144 N. Gilmor
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl Brown

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	N	Married

6 (b) Name of husband or wife George
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 14 1892

8. AGE: Years	Months	Days	If less than one day
49	10	25	hr. min.

9. Birthplace New Kent Co. Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER	12. Name Charles Wyatt
	13. Birthplace New Kent Co Va.
MOTHER	14. Maiden Name Luvenia ?
	15. Birthplace New Kent Co Va.

16 (a) Informant George Brown
(b) Address 1144 N. Gilmore St

17 (a) Burial (b) Date thereof Aug 10 /47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location A.A. County Md
18 (a) Funeral director Mrs Rob A. Elliott Jr
(b) Address 1129 N. Caroline St
19 (a) (b) Huntington Williams Mort

AUG 8 - 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/6 1947 at 2 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/5 1947 to 8/6 1947, and that I last saw her alive on 8/6 1947.

Immediate cause of death	Duration
Subarachnoid Hemorrhage	
Due to Hypertensive C-V Renal Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Paxton Grant M.D.
Address 1514 Division St Date signed 8/7/47

PLEASE WRITE PLAINLY. Fill in all blanks. Be sure to state the causes of death clearly and completely. Physicians: please write the correct age is especially important.

129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 654129

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1403 E Lanvale St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County B
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1403 E Lanvale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Nertney

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) ~~Single, married, widowed, or divorced~~

6 (b) Name of ~~husband or~~ wife Patrick Nertney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5 1866

8. AGE: Years	Months	Days	If less than one day
81	5	2	hr. min.

9. Birthplace Norfolk Va (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Michael Royle
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Conway
15. Birthplace Ireland

16 (a) Informant Mary Jacobs
(b) Address 1403 E Lanvale St

17 (a) (Burial, cremation, or removal) (b) Date thereof Aug 11-1947 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St

(Date received by registrar) AUG 8 - 1947 (Signature) Huntington Williams M.D.

VS 150

Duplicate

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 7 1947, at 2:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 7 1947, to — 19..., and that I last saw h... alive on ... 19...

Immediate cause of death: Arteriosclerotic Heart Disease — Duration

Due to

Due to

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Theodore Kardash
Address 1500 N Broadway Date signed 8-7-47 M. D.

Howard J. Wallace, M.D.

Please write correct age is especially important. Physicians:

130 BCH #72784

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 107

G54130 ✓
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hosp
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1445 Druid Hill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maureen Elandora Smith ✓

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 6 47

8. AGE: Years | Months 5 | Days 1 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Bernard Smith
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Viola Holt
15. Birthplace Pindle Md.

16 (a) Informant Viola Smith
(b) Address 1445 Druid Hill Ave

17 (a) C. (Burial, cremation, or removal) (b) Date thereof 8-8-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Co. Md.

18 (a) Funeral director Samuel W. Sullivan Jr.
(b) Address 1611 N. Charlestown Ave

AUG 8 - 1947 (D) rec'd by Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/7/47 19 ..... at 5:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/2 1947, to 8/7 1947, and that I last saw her alive on 8/7 1947.

Immediate cause of death	Duration
(a) Anoxia	
Due to (b) Obstruction	
Due to (c) Bronchial Pneumonia	
Other Conditions (d) Marked Debilitating Probable Meningitis Retarded	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: none
of autopsy: not granted

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. B. Pugh, Jr.
Address University Hosp. Date signed 8/7/47

correct age is especially important. Physicians: please write

VS 150

G54131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 127a

G54131 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 113 S. Washington St. #31
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Johanna Zoll

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14-1858

8. AGE: Years	Months	Days	If less than one day
89	4	23	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Winkler
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace Germany

16 (a) Informant Leo Zoll
(b) Address 113 S Washington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 9-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Jos J Henderson
(b) Address 3001 Kentucky Ave

AUG 8 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 August 1947, at 2:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 25 July 1947 to 6 Aug 1947, and that I last saw h... alive on 6 Aug 1947.

Immediate cause of death	Post-operative shock-	
Due to	Cholecystectomy	
Due to	Empyema of gall bladder	
Other Conditions		

(Include pregnancy within 3 months of death)

Date of operation 6 Aug 1947

Major findings of operation: Empyema of gall bladder

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John D Ross

Address West. Bell Co Nash. Date signed 6 Aug 47 M. D.

X

correct age is especially important. Physicians: please write clearly

G54132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G54132 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital. 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 916 E. Pratt Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James or Vincenzo Scarafile or Scarafili

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 18 1882

8. AGE: Years 64 | Months 7 | Days 18 | If less than one day hr. min.

9. Birthplace Lapiano Lecce Italy
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Giovanni Scarafili
13. Birthplace Italy

MOTHER
14. Maiden Name Rosa Faggiano
15. Birthplace Italy

16 (a) Informant Rocco Scarafili (BROTHER)
(b) Address 916 E. Pratt St.

17 (a) Burial (b) Date thereof 8-11-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location Belair Rd. Balto., Md.

18 (a) Funeral director Graull Della Rocca
(b) Address 52 N. Morley St.

8 (c) 1947 Huntington Williams M.D. Registrar
(Date received by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7, 1947, at 6.30 P M

21. I certify that I took charge of the remains described above, held an insp. & inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry (Autopsy, Inspection or Inquiry), find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature M.D.
Medical Examiner

Date signed 8-8-47

G54133
289943

BALTIMORE CITY HEALTH DEPARTMENT
084 CERTIFICATE OF DEATH 937

G54133
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2207 E. Chase, St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christopher C. Hardester

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Lila Hardester

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-26-73

8. AGE: Years 73 | Months 9 8 | Days 12 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name ?

FATHER 13. Birthplace ?

MOTHER 14. Maiden Name ANNIE ?

MOTHER 15. Birthplace ?

16 (a) Informant records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/11/47 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cem.

Location North Ave.

18 (a) Funeral director John C. Miller Inc.

(b) Address 213 E. Oliver St

AUG 8 - 1947
(Date rec'd by Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 8 1947, at 12 06 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-21- 1947 to 8- 8- 1947 and that I last saw h~~im~~ alive on 8- 8- 1947

Immediate cause of death: ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — Duration: 9 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Not yet Reported

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas E. Van Metre Jr. M. D.

Address Johns Hopkins Hosp Baltimore Md Date signed 8/8/47

X

Please write plainly in ink. Physicians: please be sure that the correct age is especially important.

G54134 BALTIMORE CITY HEALTH DEPARTMENT G54134
Registered No.

CERTIFICATE OF DEATH 1947

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Charles St.
(c) Hospital or institution:
Warrington Apts. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. N. Charles St. Warrington Apts.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LISETTE KOESTER

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband ~~or wife~~ Eilert H. Koester
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1860

8. AGE: Years	Months	Days	If less than one day
86	8	1	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name ? Brandt
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mr. Wm. H. Koester
(b) Address 806 St. Georges Rd.

17 (a) Burial (b) Date thereof 8/9/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Druid Ridge Vault
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

19 (a) 1947 (b) Huntington Williams M.D.
(Registered by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 7, 1947 19 , at 12 Noon M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1946 to Aug 7 1947 and that I last saw her alive on 8-7-1947.

Immediate cause of death	Duration
Carcinoma Rt Lung	8 mo.
Due to Acute Heart Failure Original	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Luther E. Leitz M. D.
Address 1 W. Madison St. Date signed 8-8-47

Direct age is especially important. Physicians: please write

VS 150

Luther E. Leitz

G54135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G54135 Registered No. 124a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1111 W. Franklin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 8 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1111 W. Franklin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Brooks James Warner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Separated

6 (b) Name of husband or wife Rose Warner
6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) June 26, 1911

8. AGE: Years	Months	Days	If less than one day
36	1	10	hr. min.

9. Birthplace Accomac Virginia
(Town, county, and state)
10. Usual Occupation Barber
11. Industry or business

FATHER
12. Name Warton Warner
13. Birthplace Va.

MOTHER
14. Maiden Name Willie Custis
15. Birthplace Va.

16 (a) Informant Rose Warner
(b) Address 435 Condent Ave., New York, N. Y.

17 (a) Burial (b) Date thereof 8/9/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Metompkin
Location Accomac, Va.

18 (a) Funeral director Elroy C. Wilson
(b) Address 1000 Brantly Ave.

19 (a) (Date rec'd by registrar) Huntington Williams Registrar
AUG 8 1947

Physician: please write the cause of death in a way that the correct age is especially important.

MEDICAL CERTIFICATION

Sick 8/4 6:15 P.M.

20. DATE OF DEATH 8/6 1947, at 6:15 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 8/4 1947 to 8/6 1947, and that I last saw h alive on 8/4 1947.

Immediate cause of death Acute cardiac fibrillation, Cardiac failure - Embolism

Due to Fibrin (thrombus) Hypertension.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
3 days
unk.
unk.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Jackson M. D.
Address 600 Washington Ave. signed

G54136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G54136 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address So Baltimore Gen Hosp
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hr. 15 min
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1450 Battery Ave.
(If rural give location)
(e) Citizen of foreign country? Not (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond Clarence Watts

3 (b) If veteran, name war	3 (c) Social Security Account No.
None.	?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1891

8. AGE: Years	Months	Days	If less than one day
? 56	7	0	hr. min.

9. Birthplace Indianapolis, Indiana
(Town, county, and state)
10. Usual Occupation House painter
11. Industry or business

FATHER
12. Name William Watts
13. Birthplace Elbridge, Maryland

MOTHER
14. Maiden Name Elinor Robinson
15. Birthplace Missouri

16 (a) Informant Claude Watts
(b) Address 1243 Light St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-9-1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md.

18 (a) Funeral director Hyson & Hagerty
(b) Address 1411 Light St.

19 (a) 1947 (b) Filed by registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 1947, at 6.45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 7 1942, to Aug 7 1947, and that I last saw him alive on Aug 7 1947.

Immediate cause of death Chronic congestive heart failure — Duration

Due to arteriosclerotic Heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lester Lebo M. D.
Address So Balto Gen Hosp Date signed 8-7-47

VS 150

X

G54137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G54137
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1925 Frederick Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1925 Frederick Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Laughlin

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife late Margaret E. Tuttle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27th 1874

8. AGE: Years	Months	Days	If less than one day
73	2	11/10	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Paper Hanger
11. Industry or business Self

FATHER
12. Name William Laughlin
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Amelia A. Dipple
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Charles Robinson
(b) Address 1429 W. Lombard St

17 (a) Burial (b) Date thereof 8/11/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Edmondson Ave & Fairwood Ave

18 (a) Funeral director John J Cavanaugh Sons
(b) Address 901-03 Hollins St

AUG 8 1947 (b)
(Date rec'd by registrar) Registrar

Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7th 1947, at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/ / 1947 to 8/ / 1947; that I last saw her alive on 8/ / 1947

Immediate cause of death	Duration
Carcinoma of colon	6 mos
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Weller M. D.
Address 1030 Williams ave Date signed 8/9/47

X

Correct age is especially important. Physicians: please write plainly.

G51138 — BALTIMORE CITY HEALTH DEPARTMENT — G51138 Registered No.

CERTIFICATE OF DEATH 1/61

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2240 Cambridge, St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2240 Cambridge, St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY KIESLING

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Julius Kiesling

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21, 1875

8. AGE: Years 72 | Months 2 | Days 15/6 | If less than one day ____hr. ____min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER — 12. Name August Kresmont
13. Birthplace Germany

MOTHER — 14. Maiden Name Augusta Douse
15. Birthplace Germany

16 (a) Informant Julius Kiesling
(b) Address 2240 Cambridge, St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8- 9- 47 (month) (day) (year)
(c) Cemetery or crematory Swartz
Location 6115 O'Donnell, St.

18 (a) Funeral director Lilly & Zailer Inc.
(b) Address 403 S. Wolfe, St. Balto.

(a) (Date received by registrar) 8 1947 (b) Registrar Huntington Willemain, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 — 6 — 1947, at 2.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8 - 5 - 1947 to 8 - 6 - 1947 and that I last saw her alive on 8 - 5 - 1947.

Immediate cause of death	Duration
Coronary Thrombosis	2 days
Due to Diabetes Mellitus	6 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N. G. Davis M. D.
Address 3218 Eastern Ave Date signed 8-7-47

age is especially important. Physicians: please write

G54139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G54139

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1214 John St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1214 John St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa Bernadine Cain

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19 1873

8. AGE: Years	Months	Days	If less than one day
74	2	19	hr. min.

9. Birthplace Cumberland Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Thomas Cain
13. Birthplace Ireland

MOTHER
14. Maiden Name Julia Maher
15. Birthplace Ireland

16 (a) Informant Ella Cain
(b) Address 1214 John St

17 (a) Burial (b) Date thereof Aug 9 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto Md.

18 (a) Funeral director Henry N. Jenkins Sons
(b) Address Mt Cuthbert - Cathedral Sts

8 (a) 1947 (b)
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 7 1947, at 3:30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 1947, to Aug 7 1947, and that I last saw h[illegible] alive on Aug 6 1947.

Immediate cause of death	Duration
Cerebral hemorrhage	12 hrs
Due to Hypertensive Arteriosclerotic disease.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm J Schmidt

Address 701 N. Desmond Ave Date signed Aug 7 47
M. D.

corrected age is especially important. Physicians, please write

54140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 54140

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1201 Walnut Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town) Roland Park Heights
(d) Street No. 1201 Walnut Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth P. Holton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ David P. Holton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19th 1850

8. AGE: Years	Months	Days	If less than one day
97	1	18	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name William Montague
13. Birthplace London England

MOTHER
14. Maiden Name Louisa Markes
15. Birthplace Balto. Md.

16 (a) Informant Miss Daisy Montague (Niece)
(b) Address 201 Walnut Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 8/9/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

AUG 9 - 1947 (Date rec'd by registrar) (b) Huntington Wilkinson, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 7th 1947, at 12 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1942 to Aug 7 1947, and that I last saw h~~e~~r alive on Aug 5 1947.

Immediate cause of death	Duration
Myocardial degeneration	
Insufficiency, Arteriosclerosis	
Congestive failure	
Due to Chronic arteriosclerotic type	
Heart disease	
Due to Generalized arteriosclerosis.	

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Mitchell M. D.
Address 2901 Eutaw Ave Date signed Aug 8 1947

X

Please write very plainly. Physician: please correct age is especially important.

54141

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. 054141

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave & Madison St.
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 617 Bartlett Ave #18
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret A. Barnes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
F	W	W

6 (b) Name of husband ~~or wife~~ Arthur Barnes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 12th 1882

8. AGE: Years	Months	Days	If less than one day
65	4	26	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name James Messick
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Murphy
15. Birthplace Md

16 (a) Informant Florence Hobbs
(b) Address 639 Bartlett Ave.

17 (a) Burial (b) Date thereof 8/11/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

AUG 9 1947 (b) Huntington Williams, M.D.
(Date rec'd by local reg.) Registrar

PLEASE WRITE PLAINLY. Physicians: please write the causes of death in such terms that correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 Aug. 1947, at 7 24 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 26 July 1947 to 8 Aug 1947.
and that I last saw h~~e~~r alive on 6 Aug 1947.

Immediate cause of death	Duration
Subarachnoid hemorrhage	14 days
Due to Hypertensive cardio-vascular disease	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Allan Spies M.D.
Address Md. Gen. Hosp. Date signed 8 Aug 47

X

VS 150

51112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Register No. C51112

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2502 W. Lanvale St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Laurence Hallameyer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married, widowed, or~~ divorced.
Male	White	Divorced

6 (b) Name of ~~husband or~~ wife Amelia Hallameyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 16th 1899

8. AGE: Years	Months	Days	If less than one day
48	6	22	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Machinists Helper
11. Industry or business Penna. R. R.

FATHER
12. Name Joseph A. Hallameyer
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Margaret Kohler
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Marie Hallameyer
(b) Address 2502 W. Lanvale St

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 8/12/47 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 AUG 9 - 1947 (Date rec'd by registrar) (c) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1947, at 10:05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH Fracture of skull & intra-cranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of ~~injury~~ 8-7-47 at ? 3:2 M.
(b) Where did injury occur? Found Central Ave & Waterside
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? no
(d) Means of injury Hit & struck head on pavement

23. Signature Earle V. Geyer M.D. Medical Examiner.
Date signed 8-8-47

51143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. C51143

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2320 E.Chase Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2320 E.Chase Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis R.Leuschel

3 (b) If veteran, name war	3 (c) Social Security Account No.
---	---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Hedwig Anna Leuschel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept.29,1867

8. AGE: Years	Months	Days	If less than one day
79	10	9	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name --- Leuschel
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs.Hedwig Anna Leuschel
(b) Address 2320 E.Chase Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug.11/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Balto, Md.

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

19 AUG 9 - 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

correct age is especially important. Physicians: please write plainly.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1944 to Aug 8 1947, and that I last saw h.. alive on Aug 8 1947.

Immediate cause of death	Duration
Chronic Myocarditis Degeneration	5 yrs
Due to Arteriosclerosis	
Due to	
Other Conditions Chronic Nephritis	5 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Lloyd Schneider M.D.
Address 1101 N Linden Ave Date signed 8-9-47

G54144 LW 106610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. G54144

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Balto. - 1203 Riverside Av
(If outside city or town limits, write RURAL and give town)
(d) Street No. ~~2 Fourteenth Ave. Brooklyn Pk.~~
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Frances Holland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Joshua Holland
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 1-1872

8. AGE: Years 75 | Months 2 | Days 6 | If less than one day ... hr. ... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Patton Carney
13. Birthplace Va.

MOTHER
14. Maiden Name Elizabeth Smith
15. Birthplace Va.

16 (a) Informant Records Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 11 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director R. Howard Evans
(b) Address 1405 E. Monument St. Huntington Williams, M.D.

19 AUG 9 1947 (Date rec'd by Reg.) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 7- 1947, at 1:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 4 1946, to Aug. 7 1947, and that I last saw her alive on Aug. 7 1947

Immediate cause of death	Duration
Carcinomatosis.	
Due to Cystadenocarcinoma of left ovary.	
Due to	
Other Conditions Obstruction of both ureters	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature William H. Uhler M.D.
Address Balto City Hosp. Date signed 7 Aug 0

Form age is especially important. Physicians: please write correct age.

VS 150

54145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30C

G54145 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 117 Burnett St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 117 Burnett Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles C. Swope

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Nellie S. Swope (nee Frank) 6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) May 1, 1889

8. AGE: Years	Months	Days	If less than one day
58	3	7	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Foreman (Labor)
11. Industry or business Bureau of Street Cleaning

FATHER
12. Name John L. Swope
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Ellen Creamer
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Nellie S. Swope
(b) Address 117 Burnett Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 12, 1947 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location A. R. Co., Maryland

18 (a) Funeral director A. Howard Evans
(b) Address 1400 N. Charles Street

AUG 9 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Fri. Aug 8 1947, at 4:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 17 1947 to Aug 8 1947, and that I last saw h. alive on Aug 7 1947.

	Duration
Immediate cause of death: Hypostatic Pneumonia	5 days
Due to: Central Nervous System Syphilis - Tabo-paresis	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature James E. Peterman
Address 1226 Hanover St. Date signed 8/9/47 M.D.

Please correct age is especially important. Physicians: please write plainly.

G54146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G54146

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 708 N. Carrollton Ave.
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 708 N. Carrollton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Virginia Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Samuel J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23, 1883

8. AGE: Years 63 | Months 8 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Amos Harvey
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary E. Causaway
15. Birthplace Balto. Md

16 (a) Informant Mr. Samuel J. Anderson
(b) Address 708 N. Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 8 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Long Green Md.

18 (a) Funeral director Chas. H. Stallings & Sons
(b) Address 1639 Druid Hill Ave

19 (Date rec'd by registrar) AUG 9 - 1947 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH (month) Aug. 5 (day) 1947, at 11½ M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947, to Aug 5 1947 and that I last saw h[illegible] alive on Aug. 5. 1947.

Immediate cause of death: Acute Intestinal Nephritis — Duration: 3 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M. D.
Address 2329 Jarrett St. Date signed Aug 7 1947

X

Please write correct age is especially important. Physicians: please write

54147 DRIVER

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1242

G54147 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1223 Ashland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1223 Ashland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah J. Driver

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	C	Widowed

6 (b) Name of husband or wife Richard Driver
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6th 1870

8. AGE: Years	Months	Days	If less than one day
76	10	-	hr. min.

9. Birthplace Balto, Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name John L. Coates
13. Birthplace Md.

MOTHER 14. Maiden Name Henrietta Carey
15. Birthplace Md.

16 (a) Informant Blanche Garris
(b) Address 1223 Ashland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 10-1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co. Md.

18 (a) Funeral director Bryant Mamie W. Wright
(b) Address 721 Aisquith St

19 AUG 9 - 1947 (Date rec'd by registrar) Thurlington Williams, M.D.

V3 153

correct age is especially important. Physicians, please give

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-6-1947 at 6 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-1-1947 to 8-6-1947 and that I last saw her alive on 8-6-1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 hours
Due to Hypertension	2 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Chas R Blake M.D.
Address 1327 N. Carrollton Ave (Date signed)
8-8-47.

54148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓183

Registered No. G54148

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 909 Bonney St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Joseph J. Clark

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 4 1936

8. AGE: Years	Months	Days	If less than one day
10 11	8	4	hr. min.

9. Birthplace Balto md. (Town, county, and state)
10. Usual Occupation school boy
11. Industry or business

FATHER
12. Name Joseph Black
13. Birthplace Balto md.

MOTHER
14. Maiden Name Annabelle Schafer
15. Birthplace Balto md

16 (a) Informant Mr. Joseph Black
(b) Address 909 E. Bonney St

17 (a) Burial (b) Date thereof Aug 11 47 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Sacred Heart Cem
Location German Hill Road
18 (a) Funeral director Marie E. Fiathorpe
(b) Address 1008 E. Kenwood Ave

AUG 9 - 1947 (b) [illegible] Registrar
Date rec'd

Correct age is especially important if deceased was under one year, one month or one day.

VS 151 11

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1947, at 12:00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Drowning

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 1-4
(a) Date of injury 8/8/47 at 11:55 a.m.
(b) Where did injury occur? Patapsco River Boston St
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Drowning while swimming

23. Signature [signature] M.D.
Medical Examiner.

Date signed 8-8-47

X

54149 MALLIE SON

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 96

Registered No. C54149

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rutland + Monument
(c) Hospital or institution: Sinai 7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 324 S Clinton
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mallie son Hoffman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Herman M Hoffman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 53? | Months | Days | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Dont Know

13. Birthplace Md

MOTHER 14. Maiden Name Connor

15. Birthplace Md

16 (a) Informant Herman M Hoffman

(b) Address 324 S Clinton

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 9/47 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Balto

18 (a) Funeral director Willard Funeral Home

(b) Address 2008 Orleans St

19 (a) AUG 9 - 1947 (Date rec'd by registrar) (b) Kensington Wilkens, Md

VS 150

correct age is especially important. Physicians: please write

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/6/47 1947, at 11:39 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/4/47 19 47 to 8/6/47 19 47 and that I last saw h[illegible] alive on 8/6/47 19 47

Immediate cause of death Subarachnoid hemorrhage — Duration 4½ day

Due to Aneurysm? brain — ?

Due to abscess

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Subarachnoid hemorrhage

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R A Cohnheim M. D.

Address Sinai Date signed 8/7/47

54150 WALKER G54150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST
(c) Hospital or institution: ST JOSEPHS HOSP
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1912

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2717 N HOWARD ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PHILIP L. WALKER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife MARY BELLE HEAPS WALKER 6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 11 1892

8. AGE: Years 55 Months 6 Days 26 If less than one day — hr. — min.

9. Birthplace FALLSTON MD.
(Town, county, and state)

10. Usual Occupation FLAGMAN

11. Industry or business M of P. RR. Co

FATHER 12. Name John Walker

13. Birthplace Maryland

MOTHER 14. Maiden Name Lillibelle Divers

15. Birthplace Maryland

16 (a) Informant Mrs. Philip Walker Sr.

(b) Address 2717 N. Howard St.

17 (a) Burial (b) Date thereof 8/10/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery ~~or crematory~~ State Ridge

Location Dulaney, Md.

18 (a) Funeral director H. H. Mears and Son

(b) Address 805 N. Calvert St Williamsport, Md.

19 (a) (Undertaker's name) (b) Registration Address

AUG 9 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-7 1947, at 8 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-6 1947 to 8-7 1947 and that I last saw h. alive on 8-7 1947

Immediate cause of death CARDIO RESPIRATORY FAILURE — Duration 24 hours

Due to CORONARY OCCLUSION

Due to CORONARY SCLEROSIS

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Examination dictated

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature John B Wells MD

Address St Josephs H. Date signed 8/7/47

Please write plainly. Physicians: please write correct age is especially important.

1151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G54151 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 8 Beechdale Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 8 Beechdale (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** John Linck Ulrich

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Katharina Boggs

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Dec 12 1876

8. AGE: Years 70 | Months 7 | Days 27 | If less than one day ____ hr. ____ min.

9. Birthplace Menlo Park Cal (Town, county, and state)

10. Usual Occupation Retired Professor

11. Industry or business

FATHER 12. Name Rudolph Ulrich

13. Birthplace Germany

MOTHER 14. Maiden Name Helena Hartmann

15. Birthplace Germany

16 (a) Informant Mrs John L. Ulrich

(b) Address 8 Beechdale Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 11 1947 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Balto. Md.

18 (a) Funeral director Henry W. Jenkins Sons Co

(b) Address McCulloh & Orchard St

AUG 9 - 1947 (Date rec'd by registrar) Huntington Williams, Md.

VS 150

MEDICAL CERTIFICATION

20. **DATE OF DEATH** August 8 1947, at 8⁰⁰ A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from December 1942, to Aug. 8th 1947, and that I last saw him alive on August 7th 1947.

	Duration
Immediate cause of death: Congestive Heart Failure	4 months
Due to: Hypertensive and Arteriosclerotic Cardiovascular Disease	16 years
Due to:	
Other Conditions: Old Mitral Rheumatic Dis.	Chronic

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Conrad Wolf M.D.

Address 11 E. Chase St. Date signed 8/9/1947

Baltimore 2 Maryland

correct age is especially important. Physicians: please write

G54152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 48a

G54152 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Green Streets

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days

(e) Length of stay in Baltimore (yrs., mos., or days) 15 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Prince George

(c) City or town Burtonsville, Md

(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. Virginia Allen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
49	8	22	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Welsin Hobbs

13. Birthplace Laurel Md

MOTHER 14. Maiden Name Mary Hungaford

15. Birthplace Europe

16 (a) Informant Mary Micheletta Key

(b) Address Burtonsville Md

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Burton Road

Location

18 (a) Funeral director W C Oldfield Co Inc

(b) Address Laurel Md

19 (a) (Date rec'd by Registrar) (b) Huntington Williams M.D.

AUG 14 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 1947, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 26 1947 to Aug 9 1947 and that I last saw her alive on Aug 8 1947.

Immediate cause of death Carcinoma of Cervix with multiple metastases

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide no

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Frank E Bramble M. D.

Address University Hospital Date signed 8/9/47

Physicians: please write the cause of death so that the correct age is especially important.

G54153 BALTIMORE CITY HEALTH DEPARTMENT G54153
CERTIFICATE OF DEATH 121a
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 512 N. Paca St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 512 N. Paca St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert A. Reed

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed or divorced: Married

6 (b) Name of husband or wife: Flora Reed

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 15th 1878

8. AGE: Years: 68 | Months: 7 | Days: 23th | If less than one day: hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation: Retired Guard

11. Industry or business: Balto. City Jail

FATHER
12. Name: Robert A. Reed
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: Sarah Thorpe
15. Birthplace: Balto. Md.

16 (a) Informant: Flora Reed (Wife)
(b) Address: 512 N. Paca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/12/47 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 10 1947

Correct Age is especially important. Physicians, please write plainly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 9th 1947, at 4a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947, to Aug. 9 1947 and that I last saw him alive on Aug. 8 1947

Immediate cause of death	Duration
Myocardial Infarction	12 hours
Due to Hypertension	10 yrs
Due to Arteriosclerosis	6 Years
Other Conditions Chronic Nephritis	6 mos.

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas J. White M. D.

Address 532 E 22nd St Date signed 8/9/47

G54157

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G54157 Registered No. 13 1a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5432 Belair Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5432 Belair Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Way

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Female	White	Married

6 (b) Name of husband ~~or wife~~ George F. Way
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 3rd 1882

8. AGE: Years	Months	Days	If less than one day
65	5	5	hr. min.

9. Birthplace Pa.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name John Weichert
13. Birthplace Pa.

MOTHER
14. Maiden Name Phoebe Fissel
15. Birthplace Pa.

16 (a) Informant W. W. Penny
(b) Address 1217 St. Paul St

17 (a) Burial (b) Date thereof 8/11/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Asbury M. E. Church
Location Reisterstown Md.
18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.
(Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

AUG 9 - 1947
AUG 10 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 8th 1947, at 7:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 8 1947, to Aug 8 1947, and that I last saw her alive on May 7 1947.

Immediate cause of death	Duration 3 hours & minutes
Cerebral Hemorrhage	
Due to arterio Sclerosis Hypertension	3 mo
Due to Acute Nephritis	3 mo
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work)
(Specify type of place)
(e) Means of injury
23. Signature S. J. A. Stevens M. D.
Address 2818 Harford Rd Date signed 8-9-47

G5415 5 86177

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13B

G5415 5 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 703 E. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Casper Ridge

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 17, 1882

8. AGE: Years 65 | Months 5 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Oyster Shucker

11. Industry or business

FATHER
12. Name John Ridge
13. Birthplace England

MOTHER
14. Maiden Name Lula Smith
15. Birthplace Germany

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 8/11/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

(d) Funeral director William Cook Inc.
(b) Address 1217 St Paul St

19 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION PM

20. DATE OF DEATH Aug. 7- 1947, at 2.55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-25- 1944 to 8-7 1947, and that I last saw h im alive on 8-7 1947.

Immediate cause of death	Duration
Pulmonary Hemorrhage	1 wk.
Due to Tuberculosis of lungs	17 yr.
Due to	
Other Conditions Generalized arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph J. Bacon Jr. M. D.
Address Balto City Hosp. Date signed 8-9-47

X

Correct age is especially important. Physicians, please

G54156 — BALTIMORE CITY HEALTH DEPARTMENT — G54156 Registered No.

CERTIFICATE OF DEATH ✓ 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5108 Richards~~on~~ Ave.
(c) Hospital or institution: Richards~~on~~
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5108 Richards~~on~~ Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY M. SNELLING

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife: Alice M. Snelling

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13th 1871

8. AGE: Years 76 | Months 3 | Days 25 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Gardner

FATHER — 12. Name (Unknown) Snelling

13. Birthplace "

MOTHER — 14. Maiden Name "

15. Birthplace "

16 (a) Informant Evelyn E. McLeod

(b) Address 125 Tyson Ave - Glenside Pa.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 8/11/47 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Parkwood

Location Parkville Md.

18 (a) Funeral director William Cook Inc.

(b) Address 127 St. Paul St.

19 (a) 8/11/47 (Date rec'd by registrar) Signature

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8, 1947, at 5.30 P M

21. I certify that I took charge of the remains described above, held an insp. & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage,

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ..... at ..... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Emily Keyser M.D. Medical Examiner

Date signed 8-9-47

G54157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G54157 Registered No.

32a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town Winchester
(If outside city or town limits, write RURAL and give town)
(d) Street No. 112 Belview Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Bertha M. Bly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: w

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mr. Bertha Bly

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2 [illegible]5

8. AGE: Years 62 | Months 5 | Days | If less than one day hr. min.

9. Birthplace Winchester, Virginia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name James E. Coffman
13. Birthplace Virginia

MOTHER 14. Maiden Name Nora V. Spicker
15. Birthplace Virginia

16 (a) Informant Mrs. Bertha M. Bly
(b) Address 112 Belview Ave Winchester Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 12-47 (month) (day) (year)
(c) Cemetery or crematory Riverview Cem.
Location Strasburg Va.

18 (a) Funeral director Ellsworth Armacost
(b) Address 391 Liberty Heights Ave Huntington Apts Baltimore, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

PLEASE WRITE PLAINLY. Physicians: please write correct age is especially important.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/9/47 19 , at 2:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/3/47 19 to 8/9/47 19 , and that I last saw h[illegible] alive on 8/9/47 19

Immediate cause of death Cause of death not determined—pending

	Duration
Due to [illegible]	
Due to Infectious hepatitis with diffuse degeneration	over
Other Conditions Chronic cholecystitis Cholelithiasis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph D. Patterson M.D.
Address Church Home & Hosp. Date signed 8/9/47

G54158

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G54158

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla (b) County
(c) City or town Miami
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2414 S.W. 19th Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nick Pisaris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Veron

6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) 4-25-96

8. AGE: Years 51 | Months 3 | Days 14 | If less than one day ____ hr. ____ min.

9. Birthplace Turkey
(Town, county, and state)

10. Usual Occupation Grocery Man

11. Industry or business

FATHER
12. Name Peter Pisaris
13. Birthplace Turkey

MOTHER
14. Maiden Name Angelo
15. Birthplace Turkey

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Aug. 12 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Miami, Fla.

18 (a) Funeral director Lambros Inc
(b) Address 4402 North ave Balto Md

19 (a) (b)
(Date received by registrar) Registrar

AUG 10 1947

Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 9 1947 at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 16 1947, to Aug 9 1947 and that I last saw him alive on Aug 9 1947

Immediate cause of death Uremia — Duration 6 mos.

Due to Hypertensive cardiovascular disease

Due to Arteriolar nephrosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Markowitz M. D.

Address Johns Hopkins Hosp Date signed 8-9-47

X

cause age is especially important. Typewriting preferred.

G54159 (X) G54159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1001 Key St. Sparrows Pt.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman Johnson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Seperated

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12 ,1900

8. AGE: Years	Months	Days	If less than one day
47	5	22	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation Labor.
11. Industry or business

FATHER
12. Name Wallace Johnson
13. Birthplace Va.

MOTHER
14. Maiden Name Elizabeth Johnson
15. Birthplace Va.

16 (a) Informant Records Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Aug 11 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Ashland Va

18 (a) Funeral director Cloyd. Wilson
(b) Address 1010 Brantley ave

19 (a) 1947 Huntington Williams M.D.
(Date received by registrar)

Correct age is especially important. Physicians, please

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 6 1947, at 9:00P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1947 to Aug. 6 1947, and that I last saw h im alive on Aug. 6 1947

Immediate cause of death	Duration
Uraemia	
Due to Arteriolar nephrosclerosis	
Due to	
Other Conditions Hypertensive Cardiovascular Disease	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury.

23. Signature William H. Hawkins M.D.
Address Balto City Hosp Date signed Aug 7 1947

X

G54160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G54160 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor Ave
(c) Hospital or institution: West Balto General Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4100 Boarman Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BERNARD DRAGON

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Dennery

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1910

8. AGE: Years	Months	Days	If less than one day
37	-		hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Real Estate

11. Industry or business

FATHER 12. Name Michael

13. Birthplace Russia

MOTHER 14. Maiden Name Uhlig

15. Birthplace Russia

16 (a) Informant WIFE

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-10-47 (month) (day) (year)

(c) Cemetery or crematory B'NAI ISRAEL

Location SOUTHERN AVE

18 (a) Funeral director JACK LEWIS INC

(b) Address 2100 EUTAW PLACE

19 (a) AUG 10 1947 (Date received by registrar) (b) Registrar

VS 150

Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 7 1947 at 8:30 PM M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/7 1947 to 8/7 1947, and that I last saw him alive on 8/7 1947.

Immediate cause of death MYOCARDIAL INFARCTION — Duration

Due to CORONARY ARTERIO SCLEROSIS

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Albert Rubinstein M.D.

Address 3005 N. North Ave Date signed 8/7/47

Correct age is especially important. Physician: please write plainly.

G54161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G54161
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave & Madison St.
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hours
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore #12
(If outside city or town limits, write RURAL and give town)
(d) Street No. 107 Enfield Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Wooden (Elizabeth Harris Wooden)

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wm. F. Wooden

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) July 20 - 1890

8. AGE: Years 57 | Months 0 | Days 19 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business ---

FATHER
12. Name William H. Harris
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Emma A. Side
15. Birthplace Phila. Pa.

16 (a) Informant Wm. F. Wooden (Husband)
(b) Address 108 W. North Ave.

17 (a) Burial (b) Date thereof 8 - 11 - 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Pikesville

18 (a) Funeral director Stewart and Mowen Co.
(b) Address 108 W. North Ave.

AUG 10 1947
(Date rec'd by Registrar) (b) Huntington Millmore Mgr. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 Aug 1947, at 8 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8 Aug 1947 to 8 Aug 1947, and that I last saw h[illegible] alive on 8 Aug 1947.

Immediate cause of death: Cerebral hemorrhage — Duration: 4 hours

Due to: Hypertensive cardio-vascular disease — Duration: 10 yrs.

Due to: ____

Other Conditions: ____
(Include pregnancy within 3 months of death)

Date of operation: ____

Major findings of operation: ____

of autopsy: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____
(Specify type of place)
(e) Means of injury ____

23. Signature A. Allan Ayres M.D.
Address [illegible] Date signed 8 Aug 1947

Physicians: please write the cause of death in ink. Exact age is especially important.

G54162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G54162 Registered No. 186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dayon & Gayde Sts
(c) Hospital or institution:
Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1939 W. Baltimore Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN McKENNA

3 (b) If veteran, name war	3 (c) Social Security Account No.
C	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	widower

6 (b) Name of husband or wife Catherine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1883.

8. AGE: Years	Months	Days	If less than one day
64	5	17	hr. min.

9. Birthplace Ireland
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Police Force

FATHER
12. Name John McKenna
13. Birthplace Ireland

MOTHER
14. Maiden Name Annadolus Horgan
15. Birthplace Ireland

16 (a) Informant Mrs. Thos. F. McKenna
(b) Address 2512 Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 (month) 11 (day) 47 (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Road

18 (a) Funeral director John C. Conway Son
(b) Address 401-03 Fallsway

AUG 10 1947 (Date rec'd by Registrar) (b)

Huntington Williamsport, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8, 1947, at 2.55 P.M.

21. I certify that I took charge of the remains described above, held an insp. & inq. thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 20/3

(a) Date of injury 8-8-47 at 2 p. M.
(b) Where did injury occur? 1939 W. Balto. St. Baltimore, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fell from 3rd story window

23. Signature M.D.
Medical Examiner.
Date signed 8-9-47

X

G51163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G51163
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A.
(b) Street address 1714 Ellamont St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1714 Ellamont St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis Annan Duncan, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of ~~husband~~ or wife Margaret Duncan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 18, 1890

8. AGE: Years	Months	Days	If less than one day
56	9	21	hr. min.

9. Birthplace Scotland
(Town, county, and state)

10. Usual Occupation Mechanical Engineer

11. Industry or business Balto. Dry Dock

FATHER
12. Name Thomas Allen Duncan
13. Birthplace Scotland

MOTHER
14. Maiden Name Ann Reid
15. Birthplace Scotland

16 (a) Informant Mrs. Margaret Duncan
(b) Address 1714 Ellamont St.,

17 (a) Burial (b) Date thereof Aug. 12, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto. Co., Md.

18 (a) Funeral director W. Howard Strong
(b) Address 3207 W. North Ave.
Huntington Williams, Mgr

19 (a) Date received by Registrar AUG 10 1947 (b) Registrar's No.
Registrar

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/8 1947, at 5:35 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to h.r. death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage

Due to Arteriosclerotic C.V. Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. S. Sulevinda M.D.
Medical Examiner.
Date signed 8/8/47

X

G54164

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

G54164 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4013 Bateman Ave.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4013 Bateman Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles M. Derr

3 (b) If veteran, name war ---

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary Hannah Derr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1879

8. AGE: Years	Months	Days	If less than one day
67	8	17	hr. min.

9. Birthplace Frederick Co., Md.
(Town, county, and state)
10. Usual Occupation Accountant
11. Industry or business Enterprise Fuel Co.

FATHER
12. Name Charles Edward Derr
13. Birthplace Frederick Co., Md.

MOTHER
14. Maiden Name Anna Mary Zimmerman
15. Birthplace Frederick Co., Md.

16 (a) Informant Mrs. Mary Hannah Derr
(b) Address 4013 Bateman Ave.,

17 (a) Burial (b) Date thereof Aug. 11, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.,

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

AUG 10 1947
VS 150

Correct age is especially important. Physicians: please

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8, 1947, at 4.20 p.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1945 to Aug 8 1947 and that I last saw him alive on Aug 8 1947.

Immediate cause of death Cardiac Asthenia — Duration 1 hr.

Due to Carcinoma of Rectum — 2 yrs.

Due to Bronchopneumonia — 1 hr.

Due to asthenia

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature E. W. Koons

Address 1202 St Paul St Date signed 8/9/47

G51165

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G51165 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 32nd St.
(c) Hospital or institution:
The Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 3

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna. (b) County —
(c) City or town York
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1267 West Kane St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Constance Louise Eberly

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 2, 1947

8. AGE: Years 0 | Months 7 | Days 2 | If less than one day — hr. — min.

9. Birthplace York, Pennsylvania
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name John Henry Eberly
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Sara Zorel
15. Birthplace York, Pennsylvania

16 (a) Informant Mrs. John H. Eberly
(b) Address York, Pennsylvania

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 11 1947 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location York, Pennsylvania

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) Filed 10 1947 (b) Registrar Huntington Williams, M.D.

Correct age is especially important. Physicians, please write plainly.

VS, 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-9-47 19 , at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 6 1947 to Aug. 9 1947 and that I last saw h[illegible] alive on Aug. 9 1947

Immediate cause of death Respiratory Failure — Duration —

Due to Contusions of the brain — 3 Days

Due to Trauma & Skull Fracture — 3 Days

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation 8-6-47

Major findings of operation: Severe contusion of brain & fracture of skull

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence July 31, 1947 M
(c) Where did injury occur? York, Penn.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? about home While at work?
(Specify type of place)
(e) Means of injury Skull fracture in fall to concrete pavement.

23. Signature [signature] M. D.

Address Union Memorial Hosp. Date signed —

Approved by Chief Deputy Medical Examiner 8-9-47

G54166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

G51166
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Jenkins Memorial - St Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 200 Hawthorn Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret M. Cassidy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19 1876

8. AGE: Years	Months	Days	If less than one day
71	-	20	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Frank Cassidy
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Callen
15. Birthplace Baltimore

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 11, 1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 905 East Biddle St
(c) Aug 9 1947 (Date rec'd by registrar) Huntington Williams Mortuary

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/8 1947, at 4:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/9 1947 to 8/8 1947, and that I last saw her alive on 8/7/47 19

Immediate cause of death Cardiac failure — Duration
Pulmonary edema - Mitral
Stenosis - Rheumatic
Due to Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. W Mintz
Address St Agnes Date signed 8/8/47

Age is especially important. Physicians: please write correctly.

VS 150

167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G54167 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 629 S. Conkling, St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 9
(e) Length of stay in Baltimore (yrs., mos., or days) 64 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 629 S. Conkling, St.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA M EBAUER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Pius Ebauer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1, 1869

8. AGE: Years	Months	Days	If less than one day
76	0	6	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Adam K Kalteneger
13. Birthplace Germany

MOTHER
14. Maiden Name Marie ?
15. Birthplace Germany

16 (a) Informant Dr. John F Ebauer
(b) Address 629 S. Conkling, St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/11/47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart,
Location German Hill Road

18 (a) Funeral director Lilly & Ziba, Inc.
(b) Address 403 S. Wolfe, St.

19 (a) Date received by registrar AUG 11 1947 Registrar

VS 150

correct age is especially important. Physicians, please

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 7 1947, at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 20 1947, to Aug 7 1947 and that I last saw h ex alive on Aug 5 1947

Immediate cause of death Coronary Thrombosis — Duration 3 mos.
Due to Arteriosclerosis
Cardio vascular Lesions
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. M. Ebauer M.D.
Address 637 S. Conkling St Date signed 8/9/47

1168 Death 8/9/47 BC# 385468

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

160a

G54168 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway + Fairmont
(c) Hospital or institution: Church Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Anne Arundel
(c) City or town SEVERNA PARK
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Hughes, Baby Girl.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 8, 1947

8. AGE: Years	Months	Days	If less than one day
			22 hr. min.

9. Birthplace BALTIMORE Md. (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name JAMES Hughes.
13. Birthplace BALTO Md.

MOTHER
14. Maiden Name SARAH BELL
15. Birthplace Indiana

16 (a) Informant ~~[illegible]~~ SARAH Hughes
(b) Address SEVERNA PARK, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 11, 1947 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location Gunnarus Hill Road

18 (a) Funeral director Selby & Zeiler Sons
(b) Address 103 S Wolfe Street

19 AUG 11 1947 (b) Huntington Williams, M.D.

VS 150

correct age is especially important. Physicians: please write plainly.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 19 47, at 2.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 8 19 47, to Aug 9 19 47 and that I last saw h[illegible] alive on Aug 9 19 47

Immediate cause of death Cessation of Respiration — Duration

Due to Intracranial Hemorrhage

Due to Birth Injury.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8/9/47

Major findings of operation: Red blood cells + Spinal fluid.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Wrather
Address Church Home + Hosp Date signed 8/10/47 M.D.

4169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 123a

Registered No. 054169

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4

2. USUAL RESIDENCE OF DECEASED:
(a) State N-J. (b) County
(c) City or town Montclair (If outside city or town limits, write RURAL and give town)
(d) Street No. 403 Claremont ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert Scott Snead

3 (b) If veteran, name war

3 (c) Social Security Account No. 060 20 4645

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Lydia Post Snead

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 1-28-90

8. AGE: Years 57 | Months 6 | Days 13 | If less than one day ..... hr. ..... min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business Lehigh Valley Pipe Co

FATHER — 12. Name Charles Scott Snead

13. Birthplace Ky.

MOTHER — 14. Maiden Name Louisa Van Hosemalg

15. Birthplace Germany

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug. 10, 1947 (month) (day) (year)

(c) Cemetery or crematory Montclair, N. J.

Location

18 (a) Funeral director Wm. J. Tickner & Sons

(b) Address North & Pa. Aves.

19 AUG 11 1947 (Date rec'd by reg.) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 10 19 47, at 9 35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 2 19 47, to Aug 10 19 47 and that I last saw him alive on Aug 10 19 47.

Immediate cause of death: Uremia — Duration

Due to: Renal Insufficiency

Due to: Chronic Pyelonephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8/6/47

Major findings of operation: Chronic Pyelonephritis

If autopsy: Chronic Pyelonephritis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Peter L. Scardino

Address Johns Hopkins Hosp. Date signed 8/10/47

X

Please write plainly. Physicians: please correct age is especially important.

G54170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G54170 Registered No. 1548 12

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3401 Garrison Blvd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., ~~mos.~~, ~~days~~) 15

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3401 Garrison Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Arietta H. Leister

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-01-9069

4. Sex: female | 5. Color or race: white | 6 (a) ~~Single~~, married, ~~widowed~~, ~~divorced~~: married

6 (b) Name of husband ~~or wife~~: Albert D. Leistar.

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) April 6, 1903

8. AGE: Years 44 | Months 4 | Days 2 | If less than one day hr. min.

9. Birthplace State line, Pa.
(Town, county, and state)

10. Usual Occupation House Wife.

11. Industry or business

FATHER
12. Name Standley W. Wade Hartle
13. Birthplace State line, Pa.

MOTHER
14. Maiden Name Edanora E. Hartle
15. Birthplace State line, Pa.

16 (a) Informant Albert D. Leister.
(b) Address 3401 Garrison Blvd.

17 (a) Burial (b) Date thereof 8 11 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Meadowridge Memorial Park
Location Washington Blvd.

18 (a) Funeral director David E. Martin
(b) Address Manchester Md

19 (a) AUG 11 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 8, 1947 at 1230 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947 to Aug 8 1947 and that I last saw h~~e~~r alive on Aug 7 1947

Immediate cause of death Anemia — Duration about 2 mo.

Carcinoma - abdominal — about 2 yrs

Due to Uremia - Kidneys - Metastases from Uterus

Due to

Other Conditions Carcinoma - Uterus Hysterectomy 1944
(Include pregnancy within 3 months of death)

Date of operation 1944

Major findings of operation: Carcinoma of Uterus

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did ~~injury occur~~?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles D Dublett M. D.
Address 222 Garrison Blvd Date signed Aug 9/47

Please write plainly. Physicians: please write correct age is especially important.

VS 150

G51171 BC# B85753 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 161a Registered No. G51171

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton + Wilkins Ave
(c) Hospital or institution:
St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Wade Ave; 28
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race W | 6 (a) Single, ~~married, widowed~~, or ~~divorced~~.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/8/47

8. AGE: Years | Months | Days | If less than one day 16 hr. 15 min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Nathan Johnson
13. Birthplace Md.

MOTHER 14. Maiden Name Evelyn Gunther
15. Birthplace Md.

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 11/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto Md.

18 (a) Funeral director Harry H. Lotzke
(b) Address 401 Edmondson Ave

19 AUG 11 1947 (b) Huntington Williams, M.D. Address St. Agnes Hospital Date signed 8/9/47

correct age is especially important. Physicians, please

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/8 1947 at 10:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/5 1947 to 8/8 1947 and that I last saw her alive on 8/8 1947

Immediate cause of death Atelectasis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles T. Brown, Jr. M.D.
Address St. Agnes Hospital Date signed 8/9/47

1172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C51172

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1600 ST. PAUL ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 53 YEARS

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1600 ST PAUL ST
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME John FREDRICK DALLMUS

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No.: NONE

4. Sex: MALE
5. Color or race: White
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: KATE MYERS DALLMUS
6 (c) If alive, give age 77 years
7. Birth date of deceased (mo., day, yr.) JANUARY 21, 1865
8. AGE: Years 82 | Months 6 | Days 19 | If less than one day ... hr. ... min.
9. Birthplace HARRISBURG, Penna (Town, county, and state)
10. Usual Occupation Retired RAILROAD ENGINEER
11. Industry or business RAILROADS

FATHER
12. Name Philip DALLMUS
13. Birthplace GERMANY

MOTHER
14. Maiden Name Unknown
15. Birthplace GERMANY

16 (a) Informant Mrs. John DALLMUS
(b) Address 1600 ST. PAUL ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/12/47 (month) (day) (year)
(c) Cemetery or crematory Moulon Park
Location Baltimore Md

18 (a) Funeral director Milburn Colston
(b) Address 1217 Eutaw Place

19 AUG 11 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 1947, at 10.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947 to August 9 1947, and that I last saw him alive on August 7 1947.

Immediate cause of death: HEART FAILURE — Duration: 4 YEARS
Due to ~~Arteriosclerosis~~ CHRONIC MYOCARDITIS
Due to ARTERIOSCLEROSIS — Duration: 4 YEARS
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Melvin N. Borden, M. D.
Address 2030 W. Fayette St Date signed 8/9/47

correct age is especially important. Physicians: please write

VS 150

G54173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G54173

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2022 Madison Ave
(c) Hospital or institution: 14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Spriggs

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 19-1868

8. AGE: Years 78 | Months 11 | Days 19 | If less than one day: hr. min.

9. Birthplace Balto. Co. Md. (Town, county, and state)

10. Usual Occupation Custodian

11. Industry or business

FATHER
12. Name Emanuel Spriggs
13. Birthplace Maryland

MOTHER
14. Maiden Name Elmira ??
15. Birthplace Maryland

16 (a) Informant Mr. Hamilton Murray
(b) Address 2022 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 11, 1947 (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location Baltimore, Md.

18 (a) Funeral director Mrs. Geo. A. Hoffman
(b) Address 1695 Druid Hill Ave.

19 (a) AUG 11 1947 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 8, 1947; at 4:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 26 1947, to Aug 8 1947, and that I last saw him alive on Aug 2 1947.

Immediate cause of death: Arteriosclerotic Heart Disease — Duration 7

Due to: Generalized Arteriosclerosis

Due to:

Other Conditions: Hypertension and Senility
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert L. Moseley Jr. M.D.
Address 2014 Linden Ave Date signed 8/9/47

Moseley X

54174

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 20E

Registered No. G54174

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1008 N. Lanvale St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Roland Taylor Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-05-1059

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Ruth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1896

8. AGE: Years	Months	Days	If less than one day
50 51	9	29	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business

FATHER
12. Name James Taylor
13. Birthplace Fredericksburg Va

MOTHER
14. Maiden Name Martha Fowler
15. Birthplace Calvert Co. Md.

16 (a) Informant Mrs. Ruth Taylor
(b) Address 1008 N. Lanvale St.

17 (a) Burial (b) Date thereof Aug. 13, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Geo. A. Hall
(b) Address 1631 Druid Hill Ave.

AUG 11 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

correct age is especially important. Physicians, pre

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 9 1947, at 9:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 3 1947, to Aug. 9 1947, and that I last saw him alive on Aug. 9 1947.

Immediate cause of death	Duration
Congestive Heart Failure	3 mo.
Due to	
Due to Luetic Heart Disease	
Other Conditions none	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

21 Signature George McDonald M.D.
Address 844 S. Carey. Date signed 8/9/47

VS 150

54175

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

G54175 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution:
Mercy Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore ✓
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1052 Myrtle Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Josh Farmer

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 4, 1903

8. AGE: Years	Months	Days	If less than one day
44	8	3	hr. min.

9. Birthplace South Carolina (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Kopper's Company

FATHER
12. Name Thomas Farmer
13. Birthplace South Carolina

MOTHER
14. Maiden Name Ettie Gray
15. Birthplace South Carolina

16 (a) Informant Lilly Belle Barnett
(b) Address 107 East Ave, Turners Station

17 (a) (Burial, cremation, or removal) (b) Date thereof 8-12-47 (month) (day) (year)
(c) Cemetery or crematory Beaver Dam Bapt
Location Spartanburg S.C.

18 (a) Funeral director Mrs Leo M. Holland
(b) Address 1631 Almond Hill Ave

19 (a) AUG 11 1947 (b) Thurlington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 7 1947, at 5:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 7 1947 to Aug 7 1947, and that I last saw him alive on Aug 7 1947.

Immediate cause of death Diabetic coma & acidosis — Duration: Less than 4 months

Due to Diabetes mellitus

Due to

Other Conditions Uremia Dehydration

(Include pregnancy within 3 months of death)

Date of operation Cannulization of

Major findings of operation: Supernevus vein Aug 7, 1947

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph Li Puma M. D.
Address Mercy Hosp Date signed 8-7-47

PLEASE WRITE correct age is especially important. Physicians: please

G54176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

Registered No. G54176

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U.S.Marine Hospital,Balto.,Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1712 Aliceann St.,Balto.,Md.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Wilson, Edward Francis

3 (b) If veteran, name war	3 (c) Social Security Account No.
- - --	- - - -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	wh	married

6 (b) Name of husband or wife Agnes Lorak Wilson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug.20,1907

8. AGE: Years	Months	Days	If less than one day
39	12 11	20	hr. min.

9. Birthplace Chicago, Ill. (Town, county, and state)
10. Usual Occupation Technical Advisor
11. Industry or business Merchant Seaman

FATHER
12. Name John Wilson
13. Birthplace India

MOTHER
14. Maiden Name Wilhemina ?
15. Birthplace Scotland

16 (a) Informant Records
(b) Address U.S.Marine Hospital,Balto.,Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-12-47 (month) (day) (year)
(c) Cemetery or crematory ST. STANISLAUS
Location Baltimore Md.

18 (a) Funeral director George A Weber
(b) Address 705 S Eutaw St

19 AUG 11 1947 Huntington Williams, M.D. Registrar

PLEASE WRITE PLAINLY. Physicians: please write the correct age is especially important.

VS 130

MEDICAL CERTIFICATION A

20. DATE OF DEATH August 9 19 47 at 10:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 5 19 47 to Aug. 9 19 47 and that I last saw h im alive on Aug.9 19 47.

Immediate cause of death	Duration
Enteritis due to unknown cause.	7 days
Gangrene of jejunum	
Due to Mesenteric thrombosis	7 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stuart M. Sessoms
Stuart M. Sessoms,Asst.Surg. 8/12/47
Address U.S.Marine Hospital Baltimore, Md.

51177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

162 B

Registered No. 51177

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1530 E. Madison St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Full Time

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1530 E. Madison St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jeanette Bowie

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Fe.	Negro	Married

6 (b) Name of husband or wife Joseph Bowie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1875

8. AGE: Years	Months	Days	If less than one day
72		12	hr. min.

9. Birthplace Baltimore MD
(Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Alexander Sharp
13. Birthplace Baltimore MD

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Baltimore

16 (a) Informant Husband Joseph Bowie
(b) Address 1530 E. Madison St

17 (a) Burial
(Burial, cremation, or removal)
(b) Date thereof Aug. 14 1947
(month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location
18 (a) Funeral director Robert L. Scruggs
(b) Address 1216 N. Caroline St

19 AUG 11 1947 (b) Huntington Williams, M
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/10 1947 2:57 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 5 1947 to Aug 10 1947 and that I last saw her alive on Aug 10 1947.

Immediate cause of death Pneumonia (Hypostatic)

Duration 10 days

Due to

Due to

Other Conditions Malnutrition Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William Garner M.D.
Address 822 N. Bond St Date signed 8/10/47 M. D.

Please write clearly—correct age is especially important. Physicians: please write distinctly.

VS 150

X

C51178
43840

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 139a

Registered No. C51178

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1234 Ashland, Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HANNA Woodyard (Hannah Elizabeth Wright Woodyard)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	Col.	married

6 (b) Name of husband or wife Lemuel Woodyard
6 (c) If alive, give age 48 years
7. Birth date of deceased (mo., day, yr.) March 17, 1905

8. AGE: Years	Months	Days	If less than one day
42	4	29	..... hr. ..... min.

9. Birthplace Md (Town, county, and State)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Clayton
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Neil
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 13 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Robert L. Gorsuch
(b) Address 1216 N. Caroline St.

19 (a) AUG 11 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 8 1947, at 10:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 8 1947 to Aug 8 1947 and that I last saw her alive on Aug 8 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 8.8.47
Major findings of operation: gen. peritonitis from ruptured uterus (tubo-ovarian)
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. R. Woodall M. D.
Address Johns Hopkins Hosp Date signed 8.9.47

X

correct age is especially important. Physicians: please write

G51179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G51179

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2202 Callow Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2202 Callow Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Schechter

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Schonour
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1862

8. AGE: Years	Months	Days	If less than one day
85			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Mordica
13. Birthplace Russia

MOTHER 14. Maiden Name Sadie
15. Birthplace Russia

16 (a) Informant Abraham Schechter
(b) Address 2202 Callow Ave

17 (a) Burial (b) Date thereof 8-11-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory B'Nai Israel
Location Southern Ave
18 (a) Funeral director Jack Lewis Inc
(b) Address 2160 Eutaw Place

19 AUG 11 1947 (b) Huntington Williams, M.D.
(Registrar's signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-10-1947, at 12 Noon M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1946 to Aug 10 1947 and that I last saw him alive on Aug 5 1947.

Immediate cause of death	Duration
Acute Cardiac failure	
Due to Old age arteriosclerosis etc	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jack J. Singer M.D.
Address 516 E. North Ave Date signed Aug 11 1947 M. D.

PLEASE WRITE PLAINLY. Fill in the cause of death clearly and correctly. Age is especially important. Physicians: please write the

G54180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No. G54180

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 106 W. Fort Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ?
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 106 W. Fort Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna M. Berger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Calvin Berger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 11- 1883

8. AGE: Years 63 | Months 11 | Days 29 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER
12. Name Peter Bannon
13. Birthplace Ireland

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Calvin Berger
(b) Address 106 W. Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 12-1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 (Date rec'd by registrar) AUG 11 1947 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9- 1947 at 6:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 19 47 to Aug 9 1947, and that I last saw h er alive on Aug 9, 19 47.

Immediate cause of death: Carcinoma of Uterus — Duration: ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A Ehrlich

Address 730 W. Balto. St. Date signed 8/11/47 M. D.

correct age is especially important. Physicians: please write

54181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C54181

1220

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edward & Gene St -
(c) Hospital or institution: University Hospt. 7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 825 N. Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Getzinger, Sarah

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Geo. Edward
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 22, 1888

8. AGE: Years: 59 | Months: 4 | Days: 19 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md
(Town, county, and state)

10. Usual Occupation: Home work
11. Industry or business: at home

FATHER
12. Name: Patrick Lee
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Mary McDermott
15. Birthplace: Baltimore

16 (a) Informant: Mrs Leo Grist
(b) Address: 107 S. Schroeder St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/13/47
(month) (day) (year)

(c) Cemetery or crematory: Western Cem
Location: Irving Park & Edmondson Ave

18 (a) Funeral director: John J. Lowe & Son
(b) Address: 1102 Hollins St

19 (a) Aug 11 1947 (Date received by registrar) Huntington Williams, M.D.

VS 150

correct age is especially important. Physicians: please write

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-10 1947, at 2-25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-9 1947, to 8-10 1947, and that I last saw her alive on 8-10 1947.

Immediate cause of death	Duration
Peritonitis	
Due to Incarcerated Ventral Hernia with	
Due to Necrosis of Bowel	
Other Conditions: Umbilical Hernia	

(Include pregnancy within 3 months of death)

Date of operation 8-9-47

Major findings of operation: Necrosis of Small Intestine, 15" resected

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: J. D. Jamison M. D.
Address: Univ Hosp Balto. Date signed 8-10-47

X

G51182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 92B

Registered No. G51182

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rutland & Monument St.
(c) Hospital or institution: Sinai Hosp. ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ✓
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5209 Elmer Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Ford

3 (b) If veteran, name war	3 (c) Social Security Account No.
✓	✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single.

6 (b) Name of husband or wife ✓
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feby 10-1925

8. AGE: Years	Months	Days	If less than one day
22	5	21	20 hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Md Trust Co

FATHER
12. Name John F. Ford
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Helen A Mooney
15. Birthplace Baltimore, Md

16 (a) Informant Mr John F. Ford
(b) Address 5209 Elmer Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/12/47 (month) (day) (year)
(c) Cemetery or crematory Mt Cathedral
Location 4300 Harford Road

18 (a) Funeral director John J. Gowan & Son
(b) Address 901-03 Holliday St

19 AUG 11 1947 (Date received by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/9/1947, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-19 1947 to 8-9 1947, and that I last saw h alive on 8-9 1947.

Immediate cause of death	Duration
Congestive Heart failure	
Due to Mitral endocarditis & Stenosis aortic insuff. & stenosis	
Due to rheumatic heart disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. F. Weitzman M.D.
Address Sinai Hosp Date signed 8-9-47

correct age is especially important. Physician: please w

X

54183 BC# F91182

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 737

G54183 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts.
(c) Hospital or institution:
University Hosp. 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr. 35 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 949 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Patricia Taylor

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age 3 years

7. Birth date of deceased (mo., day, yr.) 12/19/43

8. AGE: Years	Months	Days	If less than one day
3	7	19	hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER 12. Name Preston Matthews
13. Birthplace Va

MOTHER 14. Maiden Name Helena Taylor
15. Birthplace Va

16 (a) Informant Harriet Taylor
(b) Address 949 W. Fayette St

17 (a) Burial (b) Date thereof 8/11/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. S. Kelsey
(b) Address 1313 Preston St

19 (a) (b) Frontis Johnson Williams, M.D.
(Date rec'd by registrar)

AUG 11 1947
VS 150

correct age is especially important. Physicians, please write

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/7/47 19 , at 7:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/7/47 19 47 to 8/7/47 19 47 and that I last saw h[illegible] alive on 8/7/47 19 .

Immediate cause of death	Duration
(a) Anemia (Sickle Cell)	
Sepsis.	
Due to (b) Sickle cell anemia	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: will done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. H. Powell Jr. M. D.
Address Univ. Hosp. Date signed 8/8/47

X

54184
409678

BALTIMORE CITY HEALTH DEPARTMENT

162 CERTIFICATE OF DEATH 567

G54184
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 728 N. Carey St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lafayette Stephens.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Col.	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-18-40

8. AGE: Years	Months	Days	If less than one day
7	6	21	hr. min.

9. Birthplace N.C.
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Robert Stephens
13. Birthplace N.C.

MOTHER
14. Maiden Name Betty Bridges
15. Birthplace N. C.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 8/ /47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Asylum
Location Md

18 (a) Funeral director Geo. H. Nelson
(b) Address 1303 Presstman St Huntington Williams, Md

19 (a) (b) Registrar
(Date rec'd by local registrar)

AUG 11 1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 8- 1947 at 3 30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-22 1947 to 8-8- 1947 and that I last saw him alive on 8-8 1947.

Immediate cause of death aspiration of vomitus — Duration 5 min.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1 Aug 47

Major findings of operation: Brain Tumor, Rt hemisphere

Findings of autopsy: Aspiration of Vomitus

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur Craig M. D.
Address John Hopkins Hosp Date signed 8/7/47

correct age is especially important. Physicians: please write

G54185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B

G54185 Registered No. 14797

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1128 N. Stockton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore - Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1128 No. Stockton St. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Otha Lee Davis

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-4923

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of ~~husband~~ wife Grace Davis

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) March 16, 1903

8. AGE: Years 44 | Months 4 | Days 7 24 | If less than one day — hr. — min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Chauffeur.

11. Industry or business

FATHER 12. Name William Davis
13. Birthplace Virginia

MOTHER 14. Maiden Name Sarah Johnson
15. Birthplace Cherbton Virginia

16 (a) Informant Grace Davis
(b) Address 1128 No. Stockton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/47 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Md

18 (a) Funeral director Fred H. Kelson
(b) Address 1303 Forsythe St

19 AUG 11 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9, 1947 at 2:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/20 1946 to 8/2 1946 and that I last saw him alive on 8-2 1946.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Rheumatic Heart Disease	4 Yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R B Lighston
Address 501 Cherry Hill Rd. Date signed 8-9-47 M. D.

PLEASE WRITE: Please write the address of informant correct age is especially important. Physicians: please write the causes of death clearly.

VS 150

54186 CWK-111579

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 B

✓ G54186 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 4 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2316 Atlantic Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charlie Pleasant

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife Christina
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20-1880

8. AGE: Years	Months	Days	If less than one day
66	7	20	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-12-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion.
Location
18 (a) Funeral director Mrs. Kate R. Williams
(b) Address 3222 N. Schroeder St.
19 (a) AUG 11 1947 (Date rec'd by registrar) Huntington Williams, M.D.

correct age is especially important. Physicians, please

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 1947 at 8:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1947 to Aug. 9 1947 and that I last saw h im alive on Aug. 9 1947.

Immediate cause of death Ca of Bladder — Duration 3-4 months

Due to

Due to

Other Conditions Arter. & Hypertensive C-V Disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert A. Farber M. D.
Address Balto City Hosps Date signed 8-9-47

X

G54187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G54187 Registered No. 39c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 67

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Odenton
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME John Hood

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Hattie Hood
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Nov. 12, 1879

8. AGE: Years 67 | Months 8 | Days 27 | If less than one day ___ hr. ___ min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER — 12. Name Richard Hood
13. Birthplace Severn Md

MOTHER — 14. Maiden Name Mary Hood
15. Birthplace Severn Md.

16 (a) Informant Mrs. Hattie Hood Wife
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 8/12/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Nichols Mem. Church Cem
Location Odenton, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Ave. Balto. 17, Md.

AUG 11 1947
(Date rec'd by registrar) (b) Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-9-1947 5:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-8-1947 to 8-9-1947.
and that I last saw alive on 8-9-1947.

Immediate cause of death	Duration
Rocky Mountain	
Due to (Spotted Fever)	Hours
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Haunt [illegible] M. D.
Address [illegible] Date signed

X 7-Aug-1947

Please write in ink. Physicians: please note that correct age is especially important.

G54188 Mansor

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G54188 Registered No. 56E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Ga. (b) County
(c) City or town Valdosta
(If outside city or town limits, write RURAL and give town)
(d) Street No. 322 E. Roger St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3 (a) FULL NAME Theresa Mansor

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife JOHN P MANSOR
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) P 7-83

8. AGE: Years 64 | Months 7 | Days — | If less than one day hr. min.

9. Birthplace Syria (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER 12. Name George Basila
13. Birthplace Syria

MOTHER 14. Maiden Name THERESA ? BASILA
15. Birthplace Syria

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG. 14, 1947 (month) (day) (year)
(c) Cemetery or crematory SUNSET HILL CEM.
Location VALDOSTA, GA.

18 (a) Funeral director Walter Rundy Bradley
(b) Address 1922 W. North Avenue

19 (a) 8-11-1947 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-10-1947 at 9.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-26-47 to 8-10-1947. and that I last saw her alive on 8-10-1947.

Immediate cause of death Bronchopneumonia — Duration 2 days.
Due to Pituitary Tumor — 3 yrs.
Due to
Other Conditions adenoma ? adrenal
(Include pregnancy within 3 months of death)
Date of operation July 30, 1947
Major findings of operation: Pituitary Tumor
of autopsy Bronchopneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur B Lang M. D.
Address Johns Hopkin Hosp. Date signed 8/10/47

Direct age is especially important. Physicians, please write.

G54189

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G54189 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3700 Sixth St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Brooklyn (If outside city or town limits, write RURAL and give town)
(d) Street No. 3700 Sixth St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Bernsdhein

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	widowed

6 (b) Name of husband or wife Hulda Raddatz

6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) April 30, 1864

8. AGE: Years	Months	Days	If less than one day
83	3	7	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Merchant

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Germany

MOTHER 14. Maiden Name Unknown

15. Birthplace Germany

16 (a) Informant Augusta Arnique

(b) Address 609 Pontiac Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/11/47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Frederick Ave

18 (a) Funeral director John F Denny Inc

(b) Address 716 Light St Huntington Williams, Mgr

AUG 11 1947 (Date received by Registrar) (Registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 7 1947, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946, to Aug 7 1947, and that I last saw him alive on Aug 1 1947.

Immediate cause of death	Duration
Coronary Occ. heart attack	several years
Due to hypertension	
Due to Uremia	
Other Conditions Prostate hypertrophy hemiparesis Rt. side	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. Neubauer

Address 914 Patapsco Ave Date signed 8-7-47

PLEASE WRITE ... agest age is especially important. Physicians, please ...

G54190 ✓ G54190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3344 Old York Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3344 Old York Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William J. Nichol (Nichols)

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ellen J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12-1870

8. AGE: Years 77 | Months 10 | Days 28 | If less than one day hr. min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual Occupation: Retired
11. Industry or business:

FATHER
12. Name: John M. Nichol
13. Birthplace: Cecil Co. Md.

MOTHER
14. Maiden Name: Susanne Flemming
15. Birthplace: Balto Md.

16 (a) Informant: Florence Nichol
(b) Address: 3344 Old York Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug. 12-47 (month) (day) (year)
(c) Cemetery or crematory: H. Mary's Forrest
Location: Homeland Ave Govans

18 (a) Funeral director: John A. Hogan
(b) Address: 4201 Greenmount Av

19 (a) (Date received by registrar) (b)

AUG 11 1947

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 9th 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1947 to Aug 8 1947 and that I last saw h.. alive on Aug 8 1947.

Immediate cause of death: Pneumonia
Due to: Arteriosclerosis

Due to:

Other Conditions: Acute obstruction
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:

of autopsy:

Duration
2 weeks
years
years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: H. Huntington Williams M.D.
Address: 652 Fonthill Date signed: Aug 9/47

X

correct age is especially important. Physicians, please

G51191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 8 3 B

G51191 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Linden Ave & Madison
(b) Street address ~~1524 Hillsbrook St~~
(c) Hospital or institution: Maryland General Hosp. 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1524 Hillsbrook St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Hewitt (Clara Hewitt)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age 188 years

7. Birth date of deceased (mo., day, yr.) November 23, 1858

8. AGE: Years 65 | Months 8 | Days 16 | If less than one day ########## min.

9. Birthplace Baltimore, ~~Baltimore~~, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business —

FATHER 12. Name Ralph Hewitt
13. Birthplace Pennsylvania

MOTHER 14. Maiden Name Isabel O'Brein
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Ralph Hewitt Jr.
(b) Address Union Memorial Hosp.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/12/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave. Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 5735 Harford Avenue

19 (a) ~~Washington~~ Williams (b) ~~Washington~~ Registrar
(Date rec'd by registrar) AUG 11 1947

PLEASE WRITE PLAINLY. Physicians: please write the cause of death in such terms that a correct classification may be made. Exact age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 9 1947, at 2.01 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 2 1947, to Aug. 9 1947, and that I last saw her alive on Aug. 9 1947.

Immediate cause of death	Duration
Cerebral Thrombosis	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Allan Spiel M. D.
Address Md. Gen. Hosp. Date signed 9 Aug 47

VS 150

G54192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G54192
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1510 N.Spring Street
(c) Hospital or institution:

9

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1510 N.Spring Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.

3 (a) FULL NAME Margaret Carter

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife John H.Carter
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) May 21st., 1885

8. AGE: Years	Months	Days	If less than one day
62	2	19	######## min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Lawrence Staab
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Dora (Unknown)
15. Birthplace Maryland

16 (a) Informant LeRoy L.Carter (Son)
(b) Address 1510 N.Spring Street

17 (a) Burial (b) Date thereof 8/12/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director George J.Ruth, Inc.
(b) Address 1735 Harford Avenue

1947 (b) Washington Williams, M.D. Registrar
Rec'd by Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug.9th 1947, at 9 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 5, 1947, to Aug. 9, 1947, and that I last saw her alive on Aug. 7, 1947.

Immediate cause of death	Duration
Mitral Stenosis & Aortic regurgitation	1yr.
Due to Arteriosclerosis	5yrs.
Due to	
Other Conditions Diabetes	10 yrs.
Hemiplegia (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert G. Fitzgerald M. D.
Address 1613 E.North Ave. Date signed 8-11-47

Please write plainly. Physician: please write correct age is especially important.

VS 150

92B

G54193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Register No. G54193

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1110 RIDGELY ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTO. MD
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1110 RIDGELY ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Agnes Clark

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No.: NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6 (b) Name of husband or wife: NONE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 10, 1870

8. AGE: Years	Months	Days	If less than one day
77	0	29	hr. min.

9. Birthplace BALTO., MD (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name AUGUST CLARK
13. Birthplace MD.

MOTHER
14. Maiden Name MARY MAGAHA.
15. Birthplace MD.

16 (a) Informant SADIE RODGEY
(b) Address 1110 RIDGELY ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Aug 12, 1947 (month) (day) (year)
(c) Cemetery or crematory MT. OLIVET CEM.
Location FREDERICK AVE

18 (a) Funeral director T. T. AMBROSE, JR.
(b) 1119 FRANKLINTOWN RD

19 (a) AUG 11 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 1947, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 4, 1947 to Aug 9 1947 and that I last saw her alive on Aug 5 1947.

Immediate cause of death	Duration
Arteriosclerotic Cardio-Vascular	?
Due to	
Due to	
Other Conditions Cerebral Hemorrhage	3 mos

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Earl Pass, M.D.
Address 1001 Wilkens Ave Date signed 8-9-47

PLEASE ... correct age is especially important. Physicians: please write ...

194

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G51197 Registered No.

CERTIFICATE OF DEATH 161a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Severn (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Shifflett

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-4-47

8. AGE: Years | Months | Days | If less than one day: 2 hr. 35 min.

9. Birthplace Severn (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Jack A. Shifflett
13. Birthplace

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Loc Johns Hopkins Medical Schoo AUG 8 1947

18 (a) Funeral director Commissioner of Health
(b) Address

AUG 11 1947 (Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-4-1947 at 905 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-4-1947 to 8-4 1947 and that I last saw h[illegible] alive on 8-4-1947.

Immediate cause of death Asphyxia
Maternal Toxemia — Duration 2 hr. 35 m

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John F. Crigler, Jr. M. D.
Address Johns Hopkins Hosp. Date signed 8-6-47

correct age is especially important. Physicians, please

X

195 BC# b85330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. G51195

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1031 Willen Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jones

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 4, 1947

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace

MOTHER
14. Maiden Name Amy Jones
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Lo Johns Hopkins Medical School AUG 8 1947

18 (a) Funeral director Commissioner of Health
(b) Address

(a) AUG 11 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5 1947 at 6:10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-4- 1947 to 8-5- 1947, and that I last saw h er alive on 8-5 1947.

Immediate cause of death — Duration
Atelectasis
? Congenital heart disease
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature BC Williams M. D.
Address Johns Hopkins Hospital Date signed 8-876-47

Please see that age is especially important. Physicians: please write plainly.

VS 150

X

196 BALTIMORE CITY HEALTH DEPARTMENT ✓ G51196

CERTIFICATE OF DEATH 123

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Divison Street
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1919 Brunt Street
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Hill, Irene Henson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 5/15/12

8. AGE: Years 35 | Months 2 | Days 19 | If less than one day 25 hr. — min.

9. Birthplace Charlotte, N.C.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

MOTHER / FATHER
12. Name
13. Birthplace
14. Maiden Name Bertha Henson
15. Birthplace Charlotte, N.C.

16 (a) Informant
(b) Address

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 8-14-47 (month) (day) (year)
(c) Cemetery or crematory Brewer Hill
Location Annapolis, Md

18 (a) Funeral director J.B. Johnson
(b) Address Annapolis Md

(a) Date received by registrar AUG 12 1947 (b) Registrar Huntington Williams, M.D.

VS 150

PLEASE WRITE correct age is especially important. Physicians: please write

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 1947, at 7:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/8 1947 to 8/9 1947 and that I last saw her alive on 8/9 1947.

Immediate cause of death Intestinal Obstruction — Duration

Due to Post operative Adhesions

Due to

Other Conditions Gangrene of 10 inches of small intestine
(Include pregnancy within 3 months of death)

Date of operation 8/8/47

Major findings of operation: Gangrene of 10 inches of small intestine

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marcus W. Moore

Address Provident Hospital Date signed 8/11/47

X

197

BALTIMORE CITY HEALTH DEPARTMENT ✓ G51197

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Dennison St.
(c) ~~Hospital or~~ institution:
Crawford Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rabburton Nursing Home 2117 Dennison St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emmil K. Krauss

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Female	White	Widowed

6 (b) Name of husband William H. Krauss
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 15th 1867

8. AGE: Years	Months	Days	If less than one day
79	7	26	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name John M Nicklas
13. Birthplace Germany

MOTHER
14. Maiden Name Louisa Zink
15. Birthplace Germany

16 (a) Informant Wm L. Krauss
(b) Address 3205 Foster Ave

17 (a) Burial (b) Date thereof 8/13/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

AUG 12 1947 Huntington Williams, M.D.
(Date received by Registrar)

VS 150

PHYSICIANS: please write correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1947, at 6 50 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 7 1947, to Aug 11 1947 and that I last saw h~~er~~ alive on Aug 11 1947.

Immediate cause of death: Cerebral Hemorrhage + paralysis — Duration 3 days
Due to — Hypertension + Arteriosclerosis — Duration 7
Due to — Duration 1 day
Other Conditions Hypostatic Pneumonia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur ~~about home, on farm, industrial place, in public~~ place? While at work?
(Specify in or at place)
(e) Means of injury
23. Signature Walter D. Nisbet M. D.
Address Date signed Aug 11/47 X

198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a

G51198 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 542 Conway ST
(c) Hospital or institution:

22

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 542 W Conway St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Binkey McCray

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Kelly McCray
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 56 | Months | Days | If less than one day hr. min.

9. Birthplace Carolina Ct., S.C. (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Peter Clark
13. Birthplace S.C.

MOTHER
14. Maiden Name Louise Clark
15. Birthplace S.C.

16 (a) Informant Kelly McCray
(b) Address 542 Conway St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug 13 47 (month) (day) (year)

(c) Cemetery or crematory
Location Sumter S.C.

18 (a) Funeral director Isaiah F Brown Son
(b) Address 1058 W Montgomery St

AUG 12 1947 Tuttle for Williams M.D. (Director or Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 Aug 1947 at 5a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from 1 July 1947 to 10 Aug 1947, and that I last saw h.e alive on 10 Aug 1947.

Immediate cause of death	Duration
Aortic Insuffiency	3 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B M Rhetta Jr M.D.
Address 2134 Druid Hill Date signed 11 Aug 47

PLEASE WRITE PLAINLY. Physicians: please write correct age is especially important.

VS 150

X

4199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G54199

Registered No. 13B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 815 Leadenhall
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 815 Leadenhall
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Laverne Bagstop

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Balto Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Abraham Johnson
13. Birthplace Md

MOTHER
14. Maiden Name Mary L. Davis
15. Birthplace Md

16 (a) Informant Randolph Johnson
(b) Address 102 Denmead St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-12-47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Ct
Location Balto City

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery St

Date received AUG 12 1947 Registrar Washington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1947, at 5.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 23 1947, to Aug 7 1947, and that I last saw h[illegible] alive on Aug 7 1947.

Immediate cause of death	Duration
Pulmonary Tuberculosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James P Cayer M. D.
Address 1168 E. Monument Date signed 8-11-47

PLEASE WRITE PLAINLY. Fill the calles of death correct age is especially important. Physicians: please write

VS 150

1200 G54200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 920 East Baltimore Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ISAAC WEINBERG

3 (b) If veteran, name war	3 (c) Social Security Account No. 220-14-4163

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/7/4

8. AGE: Years	Months	Days	If less than one day
73			hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation Ticket Collector
11. Industry or business Moving Picture Theatre

FATHER
12. Name Simon ?
13. Birthplace Russia

MOTHER
14. Maiden Name Esther ?
15. Birthplace Russia

16 (a) Informant Jos. Rudman
(b) Address 3000 Chelsea Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-12-47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

AUG 12 1947 (Date rec'd by Registrar) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH August 11, 1947, at 9:25 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractures of ribs.
Fracture rt. hip.
Due to Edema of lungs.
Hypertrophy of heart.
Other Conditions Hemorrhage of adrenal
Obesity.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-9-47 at 10:40 P. M. 3/2
(b) Where did injury occur? Lloyd & Lombard Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto.

23. Signature Thos. E. Mensell M.D.
Medical Examiner.
Date signed 8/11/47

X

1201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G51201 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: SINAI HOSP 6-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 dy
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town ~~405 N. Patterson Park Ave~~
(If outside city or town limits, write RURAL and give town)
(d) Street No. 409 N Patterson Pk ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** ABE ROTHAUS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 72 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name Morris
13. Birthplace Russia

MOTHER
14. Maiden Name Katie
15. Birthplace Russia

16 (a) Informant Sidney Rosenfeld
(b) Address 409 N. Paterson Pk Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-12-47 (month) (day) (year)
(c) Cemetery or crematory Herrin Hebrew Rest
Location Jack Levin Inc

18 (a) Funeral director Jack Levin Inc
(b) Address 2100 Eutaw Place

AUG 12 1947 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/11/1947, at 5:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/11/1947 to 8/11/1947, and that I last saw h[illegible] alive on 8/11/1947.

Immediate cause of death a Myocardial infarction

Due to Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irwin Rosenfeld M.D.
Address [illegible] Date signed 8/11/47

correct age is especially important, Physicians, please

X

1202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G51202 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 7-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. Not Known
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Myers

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	?

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Not Known (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Balto

MOTHER
14. Maiden Name Unknown
15. Birthplace Balto

16 (a) Informant Hospt
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-12-47 (month) (day) (year)
(c) Cemetery or crematory Chev Shalom
Location O'Donnell St

18 (a) Funeral director Jack Levin Inc
(b) Address 2100 Eutaw Pl

AUG 12 1947 (Date received) (Registrar) Washington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 9 1947, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-17 1947 to 8-9 1947 and that I last saw h[illegible] alive on 8-9 1947.

Immediate cause of death Carcinoma

	Duration
Due to Carcinoma of Bile Duct (a)	
Due to + Duodenal fistula	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Carcinoma of Bile Duct
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature S N Siegelberg M.D.
Address Sinai Hospital Date signed 8-11-47

X

Subject age is especially important. Physicians, p[illegible]

1203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G51203 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2625 Guilford Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward James ATKINSON

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife ? Atkinson
6 (c) If alive, give age ? years
7. Birth date of deceased (mo., day, yr.) July 22, 1879

8. AGE: Years	Months	Days	If less than one day
66	0	17	..... hr. ..... min.

9. Birthplace Maryland (Baltimore)
(Town, county, and state)
10. Usual Occupation Bookkeeper
11. Industry or business

FATHER
12. Name Alfred A Atkinson
13. Birthplace Maryland

MOTHER
14. Maiden Name Agatha Jones
15. Birthplace Maryland

16 (a) Informant Mrs. Halcyon Pyne Atkinson
(b) Address 2625 Guilford avenue

17 (a) Burial (b) Date thereof 8/12/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Thomas
Location Garrison Forrest

18 (a) Funeral director Chas J. Evans & Son Inc
(b) Address 118 W. Mt. Royal Ave.

19 (a) Date received by Registrar AUG 12 1947 Huntington Williams M.D. Registrar

VS 150

correct age is especially important. Physicians: please

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 8 1947, at 6:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 4 1947, to Aug 8 1947, and that I last saw h. l. alive on Aug 8 1947.

Immediate cause of death	Duration
Bronchopneumonia	3 weeks
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John A. Fiselen
Address Union Memorial Hosp. Date signed 8/8/47
M. D.

X

L204 G54204

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 150c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 6
(e) Length of stay in Baltimore (yrs., mos., or days) 19

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2210 Orleans St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Veronica Chodnicki 86153 ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Joseph S. Chodnicki

6 (c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.) Dec 11, 1927

8. AGE: Years 19 Months 8 Days 0 If less than one day 29 hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Wife.

11. Industry or business Own Home

FATHER
12. Name Edward Pruga
13. Birthplace Pittsburgh, Penna.

MOTHER
14. Maiden Name Rose Stakowski
15. Birthplace Mt. Pleasant, Penna.

16 (a) Informant Joseph S. Chodnicki
(b) Address 2210 Orleans St.

17 (a) Burial (b) Date thereof Aug. 14, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore

18 (a) Funeral director Fred W Ozarowski
(b) Address 1930 Eastern Ave.

AUG 12 1947 (By writing for Williams, M.D.) Registrar
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/10/1947 at 8:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/10 1947 to 8/10 1947, and that I last saw her alive on 8/10 1947.

Immediate cause of death	Duration
Respiratory Failure	
Due to Pulmonary Edema	
Due to Acute Rt. Sided Heart Failure	
Other Conditions 6 hrs. post partum	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Anthony F. D'Paula M.D.
Address St. Joseph's Hosp. Date signed 8/10/47

X

correct age is especially important. Physicians, pl

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G51205

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Maryland General Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1803 Eastern ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DIMITRI SOBKO

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-06-8056

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not known?

8. AGE: Years 60 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Russian
(Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name ? Sabko
13. Birthplace Russian

MOTHER
14. Maiden Name Not known
15. Birthplace Russian

16 (a) Informant Mrs. John Sobko
(b) Address 1722 Aliceanna St

17 (a) Burial (b) Date thereof Aug-12-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Trinity Russian
Location Stoney Run Md

18 (a) Funeral director John A. Grefhauck & Sons
(b) Address 423 S. Paca St

AUG 12 1947 (b) Huntington Williams, M.D.
(Date received by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 August 1947, at 5:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3:00 PM 7 Aug 1947 to 5:50 PM 7 Aug 47.
and that I last saw him alive on 5:45 PM 7 Aug 47.

Immediate cause of death: Coronary Thrombosis — Duration 4 hrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Francis J. Brady M. D.
Address Maryland Gen. Hosp. Date signed 8-7-47

Please write plainly. Physicians: please write the correct age is especially important.

206

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

CWK-100688

G51206 Registered No. 13B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Year
(e) Length of stay in Baltimore (yrs., mos., or days) 59 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 125 N. Fulton Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Howser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2-1888

8. AGE: Years	Months	Days	If less than one day
59	4	6	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Howard Howser (D(
13. Birthplace Maryland

MOTHER
14. Maiden Name Mackie Walker
15. Birthplace Virginia

16. (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-12-47 (month) (day) (year)
(c) Cemetery or crematory Pat. Olivet
Location Baltimore
18 (a) Funeral director George A Farley
(b) Address Fulton Ave & Fayette St.
(a) AUG 12 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

Correct age is especially important. Physicians please cooperate.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1947, at 7:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 16 1946 to Aug. 8 1947, and that I last saw him alive on Aug. 8 1947.

Immediate cause of death	Duration
Pulmonary Tuberculosis	1 Year
Due to	
Due to	
Other Conditions Adenocarcinoma, prostate & Hypertrophy & Hemorrhoids & Ulcers (Include pregnancy within 3 months of death)	3 weeks

Date of operation 2-20-47
Major findings of operation: Cancer of prostate
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature E. George [illegible] M. D.
Address 4970 Eastern Ave Date signed 8-11-47

207

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46 B

G51207
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave.
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 18 Locust Drive, CS
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eugene S. Fields

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife Fields

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17 1872

8. AGE: Years	Months	Days	If less than one day
75	1	23	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name PATRICK FIELDS
13. Birthplace N.Y.

MOTHER
14. Maiden Name BRIDGET O'REILLY
15. Birthplace N.Y.

16 (a) Informant Agnes-St Agnes Hosp.
(b) Address

17 (a) Burial (b) Date thereof 8-13-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director George A Farley
(b) Address Fulton Ave & Fayette St.

AUG 12 1947 Date rec'd by local registrar Huntington Williams M.D.

VS 150

correct age is especially important. Physicians, please see that it is given.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/10/ 1947, at 7:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/22/ 1947 to 8/10 1947
and that I last saw h.... alive on 8/10/ 1947

Immediate cause of death (a) Coronary Thrombosis

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy None Done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John H. Shaw M. D.
Address St. Agnes Hospital Date signed 8/10/47

X

208

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1576

G51208 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Druid and Lombard Sts.
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Harford
(c) City or town Near Havre de Grace Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Delores Stanley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/6/47

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Havre de Grace
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Joe Aron Stanley
13. Birthplace Cash Co. N.C.

MOTHER
14. Maiden Name Lydia A. Castalow
15. Birthplace Newark Del.

16 (a) Informant Joe A. Stanley
(b) Address Havre de Grace Md.

17 (a) Burial (b) Date thereof 8/10/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Angel Hill
Location Havre de Grace Md.

18 (a) Funeral director Pennington & Son
(b) Address Havre de Grace

AUG 12 1947 Huntington Williams M.D.
(Date received by local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-7 1947, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-6 1947, to 8-9 1947, and that I last saw her alive on 8-9 1947.

Immediate cause of death Atelectasis - Infected Meningocele

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A R Mauldin M.D.

Address Univ. Hospital Date signed 8-9

correct age is especially important. Physicians: please

X

1209

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G54209 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Eutaw Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 621 S. Glover St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles H. Rieth Sr.

3 (b) If veteran, name war No.

3 (c) Social Security Account No. 000

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Mary Rieth

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Aug 15th 1885

8. AGE: Years 61 | Months 11 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Retired Street Cleaner

11. Industry or business

FATHER 12. Name John Rieth

13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant Charles H. Rieth

(b) Address 720 E. Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 12th 1947 (month) (day) (year)

(c) Cemetery or crematory Mt. Carmel Cem.

Location Baltimore Md.

18 (a) Funeral director Charles F. Dill

(b) Address 1501 E. Fort Ave.

AUG 12 1947 (Date received by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/9 1947 at 9:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/18 1947 to 8/9 1947 and that I last saw h[illegible] alive on 8/8 1947.

Immediate cause of death Malignant Hypertension Cerebral Thrombosis

Due to Hemorrhage Cerebral Artery

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 1 yr.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Theodore F. Rieth M.D.

Address 1016 S. Ellwood Ave Date signed 8/11/47

PLEASE WRITE correct age is especially important. Physicians: please write

VS 150

1210

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

G51210
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex (If outside city or town limits, write RURAL and give town)
(d) Street No. 504 Eastern Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bernard J. Cullison

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Jennie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1st 1882

8. AGE: Years	Months	Days	If less than one day
65	6	6	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Retired

FATHER
12. Name Edgar Cullison
13. Birthplace St. Marys Co.

MOTHER
14. Maiden Name Mary Emerson
15. Birthplace St. Marys Co.

16 (a) Informant Mrs. Jennie Cullison
(b) Address 504 Eastern Ave. Essex

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-11-47 (month) (day) (year)
(c) Cemetery or crematory Oak Grove
Location Eastern Ave.

18 (a) Funeral director John J. Cronin
(b) Address 418 Eastern Ave, Essex

19 (a) Date rec'd by AUG 12 1947 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 7 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 16 1947 to Aug 7 1947, and that I last saw deceased alive on Aug 7 1947.

Immediate cause of death	Duration
Cachexia	
Due to Carcinoma of Stomach.	1 mo.
Due to Obstruction	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation July 28/47 Major findings of operation: Mass in stomach.
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature S. Hedenberg M.D.
Address Sinai Hospital Date signed 8-7-47

correct age is especially important. Physicians, please

X

211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1947

Registered No. G51211

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Lutherville (If outside city or town limits, write RURAL and give town)
(d) Street No. 808 W. Seminary Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Gerhardt) Leonard Behrens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Marie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5 - 1885

8. AGE: Years	Months	Days	If less than one day
62	3	1	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Physician
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Leonard Behrens
(b) Address Lutherville Md.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 8-12-47 (month) (day) (year)
(c) Cemetery or crematory Maryland Memorial
Location Taylor Ave.

18 (a) Funeral director John J. Connolly
(b) Address 419 Eastern Ave, Baltimore

AUG 12 1947 (Date rec'd by local registrar) Huntington Williams M.D.

VS 150

correct age is especially important. Physicians, please

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 1947 at 5 50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-7 1947 to 8-9 1947 and that I last saw h. m alive on 8-9 1947.

Immediate cause of death	Circulatory and Respiratory Collapse	
Due to	Cerebral Hemorrhage left frontal area	
Due to	Hypertensive Cardio-vascular disease & Cardiac	
Other Conditions	Enlargement.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Pans a short.

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Sidney H. Poehn M.D.
Address University Hosp. Date signed 8/9/47

X

1212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G51212 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2510 Greenmount Ave.
(c) Hospital or institution: Southern Hospital & Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 85 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2510 Greenmount Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Christiana Freyer

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Chris Freyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1861

8. AGE: Years 86 | Months 6 | Days 7 | If less than one day: hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Henry Plitt
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Schisler
15. Birthplace Germany

16 (a) Informant Records; Southern Home
(b) Address 2510 Greenmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/13/47 (month) (day) (year)
(c) Cemetery Loudon Park
Location Baltimore, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

AUG 12 1947 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 9, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 2. 1947 to Aug. 9 1947. and that I last saw h[illegible] alive on Aug. 8 1947.

Immediate cause of death

	Duration
Due to cardiac Dilatation.	10 days
Due to chronic Myocarditis	several years.
Other Conditions old age.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Winfield C Blake
Address Medical Arts Bldg. Date signed 8-12-47

X

Please write clearly. Physicians: please correct age is especially important.

C13

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G51213 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1611 Linden Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-1
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1611 Linden Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Calvin R. Snyder

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Anna Hagerty
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) May 22, 1885

8. AGE: Years 62 | Months 2 | Days 19 | If less than one day ... hr. ... min.

9. Birthplace Orratana, Pa. (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Quiet May Oil Burner Co.

FATHER
12. Name Calvin R. Snyder
13. Birthplace Pa.

MOTHER
14. Maiden Name Alvina Spence
15. Birthplace Pa.

16 (a) Informant Mrs. Anna H. Snyder
(b) Address 1611 Linden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/13/47 (month) (day) (year)
(c) Cemetery New Cathedral
Location Ford Ave. Baltimore Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

AUG 12 1947 (b) Burlington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 1947, at 12.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 24 1947 to Aug 10 1947, and that I last saw ... alive on Aug 8 1947

Immediate cause of death: Coronary Occlusion — Duration 2 hrs
Due to: Arteriosclerosis
Due to:
Other Conditions: Myocardial damage due to coronary occlusion — 17 days
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John O. Ulrich, Jr.
Address 1227 Washington Blvd. Date signed 8/14/47

PLEASE WRITE PLAINLY. Physicians: please write carefully. Every correct age is especially important.

VS 150

6-8 PM — 8-10 A.M. X

1217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G51217

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 23rd & Calvert St.
(c) Hospital or institution:
Union Memorial Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County —
(c) City or town BALTIMORE CITY
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 UNION AVE
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country —

3 (a) **FULL NAME** LILLIAN MAE PAINTER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	SINGLE

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT 27, 1904

8. AGE: Years	Months	Days	If less than one day
42	10	15	4 hr. 55 min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation NONE
11. Industry or business —

FATHER
12. Name MR JOHN PAINTER
13. Birthplace Virginia

MOTHER
14. Maiden Name SUSAN HUNTLEY
15. Birthplace Virginia

16 (a) Informant Mother
(b) Address 1212 Union Ave. Baltimore Md

17 (a) Burial (b) Date thereof Aug 14 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampden

18 (a) Funeral director Beckenworth & Donovan
(b) Address 3465-67 Lakewood Ave.

AUG 12 1947 Huntington Williams, M.D.
(Date rec'd by Registrar)

VS 150

correct age is especially important. Physicians: please write plainly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1947, at 4:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1947, to Aug 11 1947, and that I last saw her alive on Aug 10 1947.

Immediate cause of death Cerebral accident — Duration 41 hrs
Due to unknown cause
Due to
Other Conditions epilepsy, mental retardation
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: not done
of autopsy congestion of brain & lungs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry G. Beckworth Jr. M.D.
Address Union Memorial Hosp. Date signed Aug 12 47

Harry G. Beckworth X

215

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 837

G51215 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2414 Hudson St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-4
(e) Length of stay in Baltimore (yrs., mos., or days) 97 ray

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2414 Hudson Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Zofia Szymaszek (Smith)

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15 1876

8. AGE: Years	Months	Days	If less than one day
71	2	26	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name ? Dolus
13. Birthplace Poland

MOTHER
14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Miss Vera Szymaszek
(b) Address 2414 Hudson Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem.
Location Balto. County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

AUG 12 1947 (Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION 754

20. DATE OF DEATH Aug 10 1947 at P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1946 to Aug 10 1947 and that I last saw h[illegible] alive on Aug 10 1947.

Immediate cause of death: Hypertensive Congestive Duration 2 days
Chronic Heart Failure - 4 yrs.
Due to Arteriosclerosis 2 yrs +

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. W. Lowry M. D.
Address 1 E. Pattersn Pl Balto Date signed 8/10/47

PLEASE WRITE correct age is especially important. Physicians: please write the causes of death clearly.

54216 | BALTIMORE CITY HEALTH DEPARTMENT | G54216

TN. 96261

CERTIFICATE OF DEATH 13B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals 24-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 10- 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1125 Battery Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Delia Miemann

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26th 1879

8. AGE: Years 67 | Months 7 | Days 14 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Lawrence Kirk (D
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Connors (D
15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (b) Date thereof 8/13/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Ave

18 (a) Funeral director John F Kenny Inc
(b) Address 714 Eight St.

19 (a) AUG 12 1947 Huntington Williams MD
(Date received by registrar)

VS 150

correct age is especially important. Physicians, please

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9th 1947 19 , at 5.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 25th 19 45 to Aug. 9th 19 47, and that I last saw her alive on Aug. 9th 19 47.

Immediate cause of death Pulm. Thr. — Duration 2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert A. Farber M. D.
Address Balto City Hosps Date signed 8-10-47

X

G54217

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No. G54217

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3625 4TH ST.
(c) Hospital or institution: BROOKLYN, MD.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3625 4TH ST. BROOKLYN (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LAURA VIRGINIA BENNETT

3 (b) If veteran, name war. —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	WIDOWED

6 (b) Name of husband or wife DAVID E.
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) JULY 11, 1865

8. AGE: Years	Months	Days	If less than one day
82	1	-	hr. min.

9. Birthplace ANNE ARUNDEL CO. (Town, county, and state)
10. Usual Occupation
11. Industry or business HOUSEWIFE

FATHER
12. Name UNKNOWN
13. Birthplace "

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace "

16 (a) Informant MRS. ANN BENNETT SANDERSON
(b) Address 3625 4TH ST. BROOKLYN

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8 14 47 (month) (day) (year)
(c) Cemetery or crematory CEDAR HILL
Location RITCHIE HGWY

18 (a) Funeral director JOHN F. DENNY, INC
(b) Address 715 LIGHT ST.

19 AUG 12 1947 (Date rec'd by registrar) Huntington Willis, Registrar

VS 150

PLEASE WRITE PLAINLY. Physicians: please write the causes in terms which will correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG 11, 1947, at 2: PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to Aug 11 1947, and that I last saw her alive on Aug 11 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to Coronary Occlusion	
Due to arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: none
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ray Kinstler, M.D.
Address 302 Polaymo Av Date signed Aug 12 M. D.

G54218

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 832

Registered No. G54218

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 West Lee St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimne
(If outside city or town limits, write RURAL and give town)
(d) Street No. 600 West Lee Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Ferguson Rawlings

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-22-3642

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Benny Rawlings

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) March 17, 1882

8. AGE: Years 33 | Months 4 | Days 26 | If less than one day hr. min.

9. Birthplace Lowpe County Va
W O 3rd Servic (Town, county, and state)

10. Usual Occupation Command US gov

11. Industry or business Fort George Meade

FATHER
12. Name Tompkins
13. Birthplace Louisa Co Va

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Ameet Ferguson
(b) Address 600 West Lee Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 15. 1947 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn
Location Baltimne City

18 (a) Funeral director Joseph A Sisly
(b) Address 66 West Bane Street

19 (a) AUG 12 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/11 1947 at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/2 1947 to 8/11 1947.
and that I last saw h alive on 8/11 1947.

Immediate cause of death Cerebral Apoplexy
Due to Paralysis

Duration

Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B M Rhetta M. D.
Address 34 W Lee Date signed 8/12/47

B.M. Rhetta, M.D.

PLEASE WRITE PLAINLY. Physicians: please write the cause of death in such a way that the correct age is especially important.

VS 150

654219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (467)

Registered No. 654219

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 9-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1633 Cornwell St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Kathryn Byrne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Thomas Byrne
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-20-1890

8. AGE: Years	Months	Days	If less than one day
56	11	20	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business Home

FATHER
12. Name Bernard Plagman
13. Birthplace Va.

MOTHER
14. Maiden Name Emma Sangster
15. Birthplace Md.

16 (a) Informant Husband (Thomas Byrne)
(b) Address 1633 Cornwell Street

17 (a) Burial (b) Date thereof Aug 13, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Libby & Zeigler, Inc
(b) Address 4103 Belair Road

19 (AUG 12 1947) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 1947, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1947 to Aug 10 1947 and that I last saw h[illegible] alive on Aug 10 1947

Immediate cause of death	Duration
Massive pulmonary embolism	
Due to phlebothrombosis - left calf	
Due to	
Other Conditions Post-Op Abd. Per. Anal. for Adenoca of rectum (Include pregnancy within 3 months of death)	

Date of operation July 30 1947
Major findings of operation: Carcinoma of Rectum
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert C. Hunter, M.D. M. D.
Address University Hosp. Date signed 8-10-47

correct age is especially important. Physicians: please write

VS 150

G54220

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓170c

Registered No. G54220

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5-1
(c) Hospital or institution: South Baltimore Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1421 Jefferson St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Bailey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced. ✓

6 (b) Name of husband or wife: Charles F. Bailey
6 (c) If alive, give age Years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 70 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Mortician

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Mary Taylor
15. Birthplace A-A-Co Md

16 (a) Informant Mrs Helen Roy
(b) Address 1421 Jefferson St

17 (a) ✓ (Burial, cremation, or removal) (b) Date thereof 8-12-47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem Pk
Location Baltimore Co Md

18 (a) Funeral director Mrs George H. Holland
(b) Address 1631 Druid Hill ave

19 AUG 12 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 1947, at 1:30 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions Fracture Rt. Tibia

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury 7-30-47 at 5:30 P M.
(b) Where did injury occur? Gov Ritchie Hiway & Chmd St
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? ---
(d) Means of injury Hearse + auto collision

23. Signature [signature] M.D. Medical Examiner
Date signed 8-7-47

X

51221

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √131a

Registered No. G51221

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3402 Dupont Ave
(c) Hospital or institution:

27-16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3402 Dupont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Salvatora Nazzario

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ late Nick Nazzario
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 2 1876

8. AGE: Years	Months	Days	If less than one day
71		8	hr. min.

9. Birthplace Cefalu Palermo Italy
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Geppi
13. Birthplace Italy

MOTHER
14. Maiden Name Josephine MESITA
15. Birthplace Italy

16 (a) Informant Orsolina Serio Daughter)
(b) Address 3402 Dupont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 13 1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

AUG 12 1947 (Date rec'd) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-10- 1947 at 8 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-28- 1947 to 8-10- 1947 and that I last saw h[illegible] alive on 8-9- 1947.

Immediate cause of death cardiac Infarction — Duration 10 days

Due to Chronic Interstitial nephritis & Cardiac hypertension — Duration several years

Due to — Duration yrs?

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Dramisino M. D.
Address Medical Arts Bldg Date signed

Please write plainly. Physicians: please write correct age is especially important.

X

G51222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 167

Registered No. G51222

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 11-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3/4 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1222 Madison Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Foreman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 2, 1921

8. AGE: Years 25 | Months 9 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Arthur Foreman
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Della Stewart
15. Birthplace Balto., Md.

16 (a) Informant Virginia Foreman
(b) Address 1222 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-47 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) AUG 12 1947 (Date rec'd by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 19 47, at 3'5 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hemorrhage
Due to Stab wound of Abdomen
Back.
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-9-47 at 2:00 A M(?)
(b) Where did injury occur Vacant front of 1434 Alford Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? no
(d) Means of injury Sharp Instrument

23. Signature [signature] M.D.
Medical Examiner.
Date signed 8-9-47

VS 181

X

51223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G54223

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U.S.Marine Hospital, Balto., Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18days
(e) Length of stay in Baltimore (yrs., mos., or days) lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 504 West Preston St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME
Miller, Daniel Augustus

3 (b) If veteran, name war: WW2

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: col

6 (a) Single, married, widowed, or divorced: mar.

6 (b) Name of husband or wife: Lucille Miller Johnson

6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1895

8. AGE: Years 52 (51) | Months 10 | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation laborer

11. Industry or business ----

FATHER
12. Name Peter Miller
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Jane Taylor
15. Birthplace Baltimore, Maryland

16 (a) Informant Records
(b) Address U.S.Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 13, 1947 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) AUG 12 1947 (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 1947, at 9:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 22 1947 to Aug. 9 1947 and that I last saw h... alive on Aug. 9 1947.

Immediate cause of death: Hypertensive cardiovascular disease — Duration: At least six mont

DISEASE: Arteriolar nephrosclerosis, Advanced Stage.

Due to: Uremia

Due to: Syphilis of undiagnosed site

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stuart M. Sessoms
Stuart M. Sessoms, Asst.Surg. 8/19/47
Address U.S.Marine Hospital Date signed

Please write plainly with pen and ink. Physicians: please write the cause of death so that it can be correctly coded. Age is especially important.

VS 150

C24 BC# 885621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓107

G54224 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1076 Fairmount Ave WEST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Boy Simms

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col	—

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 4 - 1947

8. AGE: Years	Months	Days	If less than one day
			hr. 5 min.

9. Birthplace University Hospital Baltimore (Town, county, and state)
10. Usual Occupation Newborn
11. Industry or business

FATHER
12. Name Elmer Simms
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Helen Cornish
15. Birthplace Baltimore, Md

16 (a) Informant Helen Simms
(b) Address 1076 Fairmont Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School Aug 7 1947
18 (a) Funeral director Commissioner of Health
(b) Address
(c) (Date received by registrar) AUG 12 1947 Health Department, Baltimore, Md.

PLEASE WRITE ... correct age is especially important. Physicians: please write ...

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 4 1947, at 12 ~~M~~ PM
21. I certify that death occurred on the date above stated; that I attended deceased from Aug 4 1947, to Aug 4 1947, and that I last saw him alive on Aug 4 1947

Immediate cause of death: Bronchopneumonia
atelectasis — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ben Gold M. D.
Address University Hospital Date signed 8-6-47

X

51225 BALTIMORE CITY HEALTH DEPARTMENT G51225

BC-H-98274 CERTIFICATE OF DEATH 1579 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Church Home & Hospital
(c) Hospital or institution: 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 37 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4220 Berger Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Lobig, Baby Boy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
37 HRS. 1		1	13 hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Lobig
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Kleiser
15. Birthplace Maryland

16 (a) Informant Elizabeth Lobig
(b) Address 4220 Berger Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School AUG 7 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 AUG 12 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 1947, at 3:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/4 19 47 to 8/6 19 47 and that I last saw h/m alive on 8/6 19 47

Immediate cause of death	Duration
Atresia of Large Bowel.	
Due to Congenital Causes	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 8/6/47
Major findings of operation: Atresia of Large Bowel
of autopsy: Atresia of Large Bowel

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature George W Mahon
Address Church Home Date signed 8/7/47 M. D.

Please correct age is especially important. Physicians, please

VS 150

54226

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 124a

Registered No. 054226

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital, Balto., Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Annapolis
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 West Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John Paul Kaadtman

3 (b) If veteran, name war: WW I

3 (c) Social Security Account No. 215-24-7530

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Ruby Kaadtman

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1892

8. AGE: Years 55 | Months 5 | Days 15 | If less than one day: hr. min.

9. Birthplace Copenhagen, Denmark
(Town, county, and state)

10. Usual Occupation - -

11. Industry or business - -

FATHER
12. Name ?
13. Birthplace Copenhagen, Denmark

MOTHER
14. Maiden Name Mary Olhrick
15. Birthplace Copenhagen, Denmark

16 (a) Informant Records
(b) Address U. S. Marine Hospital, Balto., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 12 1947 (month) (day) (year)
(c) Cemetery or crematory Balto. Nat. Cem.
Location Frederick Rd. Catons.

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Hgts. Ave.

19 (a) AUG 12 1947 (Date rec'd by Registrar) Huntington Williams, M.D. (Registrar)

PLEASE WRITE PLAINLY. Physicians: please write correct age is especially important.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 19 47, at 9:30P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 4 19 47, to Aug. 9 19 47 and that I last saw him alive on Aug. 9 19 47.

	Duration
Immediate cause of death Ruptured esophageal varix	1 week
Due to Laennecs cirrhosis	1 yr. plus
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surg. Clinical Director, M. D.
Address USMarine Hospital, Balto., Md. Date signed 8/11/47

X

541227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G541227
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John Sts. 21
(c) Hospital or institution:
Hospital for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore - 15
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3004 Oakford Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Irene Reama

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Herman Harold Reama
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) October 17, 1879

8. AGE: Years 67 | Months 10 | Days 7 | If less than one day: hr. min.

9. Birthplace Meriden, Connecticut
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Hagvleins
13. Birthplace Massachusetts (?)

MOTHER
14. Maiden Name Emily Hodson
15. Birthplace Meriden, Connecticut

16 (a) Informant Husband - Herman Reama
(b) Address 3004 Oakford Ave. Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/13/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn Md.

18 (a) Funeral director C. Vernon Zimmerman
(b) Address 5th. Ave.

19 (a) AUG 12 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 1947, at 7:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 10 1947, to Aug. 10 1947, and that I last saw her alive on Aug 10 1947.

Immediate cause of death	Duration
Cardio-Respiratory failure	ave
Due to Generalized Peritonitis	1 1/2 da
Due to Obstruction of Colon & Rupture	5-10 yrs ? 4-8 hrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of ~~operation~~ autopsy: Obstruction + dilated colon & perforation + generalized peritonitis

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James R. McCord Jr. M.D.
Address Woodens Hospital Date signed 8/10/47

PHYSICIAN
Underline the cause to which death should be charged statistically.

C. J. Lubinski MD per G. G. Merrill MD

VS 130

PLEASE WRITE PLAINLY. Physicians: please correct age is especially important.

228 CWK-112704

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G54228 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 36 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 9 N. Preston Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
James Riley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr) Oct. 27-1881

8. AGE: Years 65 | Months 9 | Days 15 | If less than one day hr. min.

9. Birthplace Kentucky
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business Steam fitter

FATHER
12. Name Harrison Riley
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Margaret Ryan
15. Birthplace Pennsylvania

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 8/14/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto. Md.
Location

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St Paul St.

(a) AUG 13 1947 (Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1947, at 2:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 3 1947, to Aug. 12 1947, and that I last saw him alive on Aug. 12 1947.

Immediate cause of death	Duration
Uremia	7 D
Cardiac insufficiency	
Due to Hypertensive Cardio-vascular disease	7
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Enlarged heart, nephritis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Balt. City Hosp. Date signed 8-14-47

VS 150

correct age is especially important. Physicians, please

X

229

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G54229
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2026 Ellsworth St.
(c) Hospital or institution:
8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2026 Ellsworth St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Kress

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Ferdinand Kress
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 16, 1864

8. AGE: Years	Months	Days	If less than one day
82	11	26	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown Comber
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown Unknown
15. Birthplace Germany

16 (a) Informant John Kress
(b) Address 2026 Ellsworth St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-15-47 (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location Eastern Ave.

18 (a) Funeral director Wm. Cook Inc.
(b) Address 1217 St. Paul St.

AUG 13 1947 (Date rec'd by Registrar) (b) [illegible] Washington Village, Md.

correct age is especially important. Physicians, please

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1947, at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1947 to Aug 12 1947, and that I last saw her alive on Aug 1 1947.

Immediate cause of death Myocardial Insufficiency
Due to: Conditions of Arteriosclerosis

Duration
?

Due to
Other Conditions Senility
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lemuel Bull M. D.
Address 1221 N. Luzerne Ave. Date signed Aug 13 1947

X

230 BC# 243079

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓9

G51230 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Herring Run & Harford Road
(c) Hospital or institution Lyndenhurst Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3603 Frankford Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Wayne Neuhauser

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 9, 1946

8. AGE: Years	Months	Days	If less than one day
1	5	2	hr. min.

9. Birthplace Balto. Maryland (Town, county, and state)
10. Usual Occupation child
11. Industry or business —

FATHER
12. Name John Calvin Neuhauser
13. Birthplace Glen Arm Maryland

MOTHER
14. Maiden Name Mary Price
15 Birthplace Balto. Md.

16 (a) Informant John Calvin Neuhauser
(b) Address 3603 Frankford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director Howard N. Blight Jr.
(b) Address 4914 Belair Road

19 (a) Date received AUG 13 1947 (b) Registrar Huntington Williams M.D.

correct age is especially important. Punctuate. Spell out words.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 August 1947 at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10 Aug. 1947 to 11 Aug. 1947 and that I last saw him alive on 11 Aug. 1947

Immediate cause of death Respiratory Failure — Duration
Due to Bronchopneumonia
Due to Burns.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. M. Bacon Jr. M.D.
M. D.
Address Lyndenhurst Hospital Date signed Aug 4

X

231

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G51231 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton and Wilkens Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town ~~Baltimore~~ Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 215 Dalton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert Elmer Mules or H. Elmer Mules.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Edna Newton Mules
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6-1881

8. AGE: Years	Months	Days	If less than one day
66	9	11	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Merchant
11. Industry or business Grocery Business

FATHER
12. Name Charles Mules
13. Birthplace Maryland

MOTHER
14. Maiden Name Kate Williams
15. Birthplace Maryland

16 (a) Informant Mrs. Edna Mules.
(b) Address 215 Hilton ave Catonsville

17 (a) Burial (b) Date thereof Aug. 15-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md

18 (a) Funeral director Geo F. Beyer Jr
(b) Address 1512 Hollins St

19 AUG 13 1947 (b) Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/12 1947, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/6 1947, to 8/12 1947 and that I last saw h. alive on 8/12 1947

Immediate cause of death Acute Coronary Occlusion a. T. Thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation:
of autopsy: NONE DONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John W. Shaw M.D.
Address St. Agnes Hosp. Date signed 8/12/47

X

Please correct age is especially important. Physicians, please

1232

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓94a

Registered No. C51232

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Monument St
(c) Hospital or institution:
Johns Hopkins Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore ✓
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1022 E. Lombard Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Wm. Brenner

3 (b) If veteran, name war

3 (c) Social Security Account No. 234-01-8910

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife Beatrice Brenner
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb-2-1898

8. AGE: Years	Months	Days	If less than one day
49	6	9	hr. min.

9. Birthplace Martinsburg W. Va.
(Town, county, and state)
10. Usual Occupation Wool Weaver.
11. Industry or business

FATHER
12. Name Samuel C Brenner.
13. Birthplace W. Va.

MOTHER
14. Maiden Name Ida F. Groove.
15. Birthplace W. Va.

16 (a) Informant Mr. A. W. Evans.
(b) Address P.O. Box Bannonstang Pa

17 (a) Burial (b) Date thereof Aug 14-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Northourne
Location Martinsburg W. Va.
18 (a) Funeral director Geo. L. Baker Jr
(b) Address 1512 Hollins St

AUG 13 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9, 1947 at 11.30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary thrombosis.
Edema of lungs.
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Thos. G. Merrill M.D.
Medical Examiner.
Date signed 8-11-47

1233

BALTIMORE CITY HEALTH DEPARTMENT

LW 112297

CERTIFICATE OF DEATH

46 B

G54233 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: 16
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1001 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kenneth Goodman

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 246-12-9862

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary Goodman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10 -1908

8. AGE: Years 38 | Months 11 | Days 0 | If less than one day hr. min.

9. Birthplace N.C.
(Town, county, and state)

10. Usual Occupation Stevedore

11. Industry or business

FATHER
12. Name Lee Goodman
13. Birthplace N.C.

MOTHER
14. Maiden Name Hattie Hartfield
15. Birthplace N.C.

16 (a) Informant Records Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem'l. Pk.
Location Balto. County, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave

19 (a) [illegible] (b)

AUG 13 1947 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10 1947, at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-19 1947, to Aug. 10 1947, and that I last saw him alive on Aug. 10 1947.

Immediate cause of death Secondary Ca
of Lungs

Due to Ca of Stomach

Due to

Other Conditions Carcinomatosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy As above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert A. Farber M. D.
Address Balto City Hosps Date signed 8-10-47

X

Correct age is especially important. Physicians, please

1231 ✓ G51231

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1090

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 333 N. Bruce Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 333 N. BRUCE Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME BELL COLEMAN

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: JOHN COLEMAN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-1884

8. AGE: Years 63 | Months 6 | Days | If less than one day: hr. min.

9. Birthplace ANNE ARUNDEL County (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Benjamin Naylor
13. Birthplace ANNE Arundel

MOTHER
14. Maiden Name SUSAN Naylor
15. Birthplace ANN ARUNDEL County

16 (a) Informant IRVING COLEMAN
(b) Address 333 N. Bruce Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-13-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. K. R. Williams
(b) Address 322 N. Schroeder St
AUG 13 1947 (Date received by local registrar) (b) Huntington Williams, M.D.

PLEASE WRITE PLAINLY. Physicians: please write correct age is especially important.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10, 1947, at 9:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from August 8, 1947, to August 10, 1947, and that I last saw her alive on August 9, 1947.

Immediate cause of death	Duration
CARDIAC FAilure	Day
Due to Acute Pulmonary Congestion	2 DAYS
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard H. Hunt
Address 1631 W. Franklin St. Date signed 8/11/47

X

1235

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. G51235

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: PROVIDENT HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2415 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MRA SUSIE A. MARTIN

3 (b) If veteran, name war

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife JAS. A. MARTIN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 8, 1875

8. AGE: Years	Months	Days	If less than one day
71	8	3	hr. min.

9. Birthplace ALLENVILLE, ALA. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Jefferies
13. Birthplace Virginia

MOTHER
14. Maiden Name Francis Brown
15. Birthplace Unknown

16 (a) Informant Mrs Mattie Connor (Daughter)
(b) Address 2415 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 15, '47 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Sulmer, Ala.

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Ave.

AUG 13 1947 (Date received by Registrar) Washington Williams M.D.

VS 150

Please write correct age is especially important. Physicians:

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 1947 at 6.05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 15 1947, to Aug 11 1947, and that I last saw her alive on Aug 11 1947.

Immediate cause of death Myocardial failure — Duration 2 Wks

Due to

Due to

Other Conditions Generalized arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Moore Adams, M. D.
Address 238 N Carey St Date signed 8-11-47

X

236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G51236

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2531 Boyd St
(c) Hospital or institution: do

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2531 Boyd St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Sophie Hawkins Hawkins

3 (b) If veteran, name war no

3 (c) Social Security Account No. no

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife John Hawkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6 1886

8. AGE: Years 61 Months 5 Days 6 If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Dont know
13. Birthplace " "

MOTHER
14. Maiden Name " "
15. Birthplace " "

16 (a) Informant Henry J Hawkins.
(b) Address 2531 Boyd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 15 1947 (month) (day) (year)
(c) Cemetery or crematory Lauel Ch Pk
Location Balto

18 (a) Funeral director A. J. Hofgard Estate
(b) Address 1400 N. Charles St

19 (a) Aug 13 1947 (Date received by registrar) (b) Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1947, at 6.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 10 1947 to Aug. 12 1947, and that I last saw h alive on Aug. 11 1947.

Immediate cause of death	Duration
Coronary occlusion	1 Day
Due to Arteriosclerosis, coronary artery	1 year
Due to	
Other Conditions Diabetes mellitus	10 years

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Gilbert E. Rudman M. D.
Address 2517 W. Balto St. Date signed 8/13/47

Please correct age is especially important. Physicians, please

94a

1937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G541237 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4700 Harford Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophia Wisebaugh

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Widowed

6 (b) Name of husband or wife Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29, 1869

8. AGE: Years	Months	Days	If less than one day
78	1	12	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name William Seidenstricker
13. Birthplace B alto. Md.

MOTHER
14. Maiden Name not known
15. Birthplace " "

16 (a) Informant William Seidenstricker
(b) Address 1110 N. Kenwood Ave.

17 (a) Burial (b) Date thereof 8/13/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory B altimore
Location North Ave. & Rose St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. B roadway

AUG 13 1947 (b) Huntington Williams M.D.
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 10 1947 at 1 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to Aug 10 1947
and that I last saw h alive on Aug 9 1947

Immediate cause of death Hypostatic Pneumonia — Duration 2 wks
Due to Cardiac Failure
Due to Arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Fred Ruzicka M.D.
Address 600 N Patterson Pk Date signed

Please see that age is especially important. Physicians: please write correct age.

1238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G51238
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1224 N. Patterson Park Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 4
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1224 N. Patterson Park Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John Lorentz Kaspar

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-4374

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of ~~husband~~ or wife Josefa Turek
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/3/1873

8. AGE: Years	Months	Days	If less than one day
74	4	8	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Painter
11. Industry or business Gardner Constr. Co.

FATHER
12. Name John Kaspar
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Charles J. Kaspar
(b) Address Route 16, Box #64, Balto-21-Md.

17 (a) Burial (b) Date thereof 8/14/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Holy Redeemer
Location 4430 Belair Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) Date Received (b) [illegible]
AUG 13 1947

VS 150

correct age is especially important. Physicians, please

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 2 1947 to Aug 11 1947 and that I last saw him alive on Aug 10 1947.

Immediate cause of death Coronary Occlusion — Duration 10 minutes
Due to Cardio-Vascular-Renal Disease (arteriosclerotic) — ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Pakorny M. D.
Address 2200 E Madison St Date signed 8/12/47

X

239 BH #31070

BALTIMORE CITY HEALTH DEPARTMENT ✓

CERTIFICATE OF DEATH 14

Registered No. G51239

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore 15
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1040 N. Mount St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Lilla Mae Mayo

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) 8-23-47

8. AGE: Years 0 | Months 1 | Days 20 | If less than one day ..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Sam Mayo
13. Birthplace Va.

MOTHER
14. Maiden Name Annie Terry
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/13/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location West Port Md

18 (a) Funeral director Metropolitan Funeral Home
(b) Address 927 N. Mount St

19 (a) Date received by registrar AUG 13 1947 (b) Registrar Huntington Williams, M.D.

VS 150

Please correct age is especially important. Physicians: please write plainly.

MEDICAL CERTIFICATION 15

20. DATE OF DEATH Aug. 12 1947, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 7 1947, to Aug 12 1947, and that I last saw h[illegible] alive on Aug 12 1947.

Immediate cause of death	Duration
Due to Tuberculous Meningitis and Pneumonia	3 weeks
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature Philip Bruce M. D.
Address Johns Hopkins Hosp. Date signed 8-13-47

X

1210 BALTIMORE CITY HEALTH DEPARTMENT G51210

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1036 Poplar Grove St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 73 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1036 Poplar Grove St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William A. Mentzel

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-03-6487

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	married

6 (b) Name of husband or wife Anna Mentzel
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) May 26 - 1874

8. AGE: Years	Months	Days	If less than one day
73	2	15	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Retired Dept. Md. Routing

FATHER
12. Name Laurence Mentzel
13. Birthplace Germ. Md.

MOTHER
14. Maiden Name Mary Borgeaut
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Anna Mentzel
(b) Address 1036 Poplar Grove St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 14, 47 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.
(c) [illegible] Huntington Williams M.D.

AUG 13 1947

PLEASE WRITE PLAINLY. Physicians: please be correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10 1947, at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 11 1947, to Aug. 10 1947, and that I last saw h[illegible] alive on Aug 9 1947.

Immediate cause of death

	Duration
Coronary Thrombosis	8/10/47
Due to Chr. Myocarditis	1946
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 1662 North Ave. Date signed 8/11/47

VS 150

211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G51211

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3604 Mohawk Ave.
(c) Hospital or institution:
Anderson's Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1001 St. Paul St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Roberta Constable Waldron

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife Ethelbert Waldron
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 17, 1864

8. AGE: Years	Months	Days	If less than one day
82	11	26	hr. min.

9. Birthplace Chestertown, Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name William R. Constable
13. Birthplace Kent County, Md.

MOTHER
14. Maiden Name Frances Hodges
15. Birthplace Kent County, Md.

16 (a) Informant Mr. Richard Bernard
(b) Address 1312 John St.

17 (a) Burial (b) Date thereof 8/15/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Old St. Paul's
Location Chestertown, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1930 Eutaw Place

AUG 13 1947 Huntington Williams M.D.
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 12 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 11 1947, to Aug. 12 1947, and that I last saw h.e.r. alive on Aug. 12 1947

Immediate cause of death Coronary thrombosis — Duration 2 hrs.
Due to Arteriosclerotic cardiovascular disease, severe
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John A Hesbitt, Jr. M. D.
Address 20 E. Preston St. Date signed 8/13/47

Dr. John Hesbitt - 20 E. Preston St.

VS 150

PLEASE WRITE PLAINLY. Physicians: please write correct age is especially important.

1942

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1637

Registered No. G51242

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Hyde
(If outside city or town limits, write RURAL and give town)
(d) Street No.....
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country.....

3 (a) FULL NAME Milford Isaiah Guyton

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 217-07-5584

4. Sex: M

5. Color or race: W.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Helen Tawney Guyton

6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) July 27, 1900

8. AGE: Years 47 | Months — | Days 16 | If less than one day — hr. — min.

9. Birthplace Long Green, Balto. Co., Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Tavern Operator

FATHER
12. Name Isaiah Guyton
13. Birthplace Md.

MOTHER
14. Maiden Name Ella J. Beares
15. Birthplace Md.

16 (a) Informant Helen T. Guyton
(b) Address 2713 Strathmore Ave, Balto. 14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 15, 1947 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill Cem.
Location Towson, Md.

18 (a) Funeral director John Burns' Sons
(b) Address Towson, Md.

AUG 13 1947 (Date rec'd by registrar)

Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/12 1947, at 7:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Mercury Poisoning

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-12-47 at ? P. M.
(b) Where did injury occur? Hyde, Md (Woods)
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Ingested Mercury

23. Signature Carl R. King M.D.
Medical Examiner.

Date signed 8-13-47

X

243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

✓ G51243 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1405 Lingan Alley (If no street give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country Virginia

3 (a) FULL NAME Owens Hamlett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ethel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 192

8. AGE: Years	Months	Days	If less than one day
23	2	29	hr. min.

9. Birthplace Lynchburg, Va (Town, county and state)

10. Usual Occupation Waiter

11. Industry or business

FATHER
12. Name Charles Hamlett
13. Birthplace Salisbury, N.C.

MOTHER
14. Maiden Name Lizzie Hampton
15. Birthplace Charlotte Co. Va

16 (a) Informant Joseph P. Calloway
(b) Address 1405 Low Pig Alley

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 14, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director Chas. H. Holland
(b) Address 1631 Druid Hill Ave

AUG 13 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1947, at 11:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gun shot wound of Heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-8-47 at 11:30 P.M.
(b) Where did injury occur? Fairmount Ave. & Eden St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? no
Means of injury Firearms

Signature Earl L. Gorsuch M.D. Medical Examiner.

Date signed 8-9-47

X

244

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G54244 133B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address DUKELAND ST - RAYNOR AVE
(c) Hospital or institution:
WEST BALTIMORE GEN'L 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 75yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2719 Ellicott Driveway
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY WEBSTER (HARRY PRETTYMAN WEBSTER)

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 214-18-1894

4. Sex: MALE
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Bessie M. Windsor
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) November 13, 1874

8. AGE: Years 73 | Months 8 | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace Deals Island, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business CARPENTER

FATHER
12. Name Jacob Webster
13. Birthplace Maryland

MOTHER
14. Maiden Name Rose Jones
15. Birthplace Maryland

16 (a) Informant Mr. Windsor Webster (son)
(b) Address 816 N. Whitmore Ave. -16

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 14. 1947 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address Baltimore Md.

19 AUG 13 1947 (Date rec'd by local reg.) (Signature of local reg.) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION E.S.T.

20. DATE OF DEATH August 11 1947, at 9.05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/29 1947 to 8/11 1947 and that I last saw h[illegible] alive on 8/11 1947

Immediate cause of death Cardio-respiratory arrest. — Duration

Due to Uremia.

Due to Bilateral hydronephrosis

Other Conditions Pulmonary oedema

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leonard Tucker M.D.
Address West Baltimore Date signed Aug 13 47

correct age is especially important. Physicians, please

1215 BALTIMORE CITY HEALTH DEPARTMENT Registered No. C51215

CERTIFICATE OF DEATH 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1913 Cecil Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JENNIE BLANEY

3 (b) If veteran, name war	3 (c) Social Security Account No.	
no	none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widowed

6 (b) Name of husband or wife George Blaney
6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) Nov. 13. 1867

8. AGE: Years	Months	Days	If less than one day
79	9	1	hr. min.

9. Birthplace Ireland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Ireland

MOTHER
14. Maiden Name Not Known
15. Birthplace Ireland

16 (a) Informant Mrs. Anna Brian
(b) Address 1913 Cecil Ave.

17 (a) Burial (b) Date thereof Aug. 14. 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address Baltimore Md.

AUG 13 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION 55

20. DATE OF DEATH August 12, 1947, at 1: A. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 8/12/47

VS 151

1246

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. C51246

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 Tunbridge Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 85 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 600 Tunbridge Rd.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN JOSEPH PRATT SR.

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Anna Hora Pratt
6 (c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) Feb. 8. 1860

8. AGE: Years	Months	Days	If less than one day.
87	6	3	....hr. ....min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business Retired

FATHER
12. Name ? Pratt
13. Birthplace Austria

MOTHER
14. Maiden Name
15. Birthplace Austria

16 (a) Informant Mr. John J. Pratt Jr.
(b) Address 600 Tunbridge Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 14. 1947 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address Baltimore Md.

AUG 13 1947 (Date rec'd by Registrar) (By) Huntington Williams, M.D. Registrar

V S 150

correct age is especially important—physicians please

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11. 1947 at 5.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan-10 1939 to Aug 11 1947 and that I last saw h IM alive on Aug 11 1947

Immediate cause of death Coronary Occlusion — Duration 1 day
Due to Arteriosclerotic — 1939
Cardio Vascular Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas W. Edwards M. D.
Address 2746 Mc Alwood 12-Aug 47 Date signed

X

G51217

BALTIMORE CITY HEALTH DEPARTMENT ✓ 61

CERTIFICATE OF DEATH

G51217 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 432 Federal St.
(c) Hospital or institution:
17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 432 E. Federal St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Simmons

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 10, 1880

8. AGE: Years	Months	Days	If less than one day
67	5	1	hr. min.

9. Birthplace Crowe, Va. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Clem Fitzgerald
13. Birthplace Va.

MOTHER
14. Maiden Name Julia Fitzgerald
15. Birthplace Va

16 (a) Informant Bessie Simmons
(b) Address 432 E. Federal St.

17 (a) Burial (b) Date thereof 8/15/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Crowe, Va.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly Ave.

19 (a) 8-13 1947 (b) Clayton Williams, M.D. Registrar
(Date rec'd by reg.)

VS 150

Correct age is especially important. Physicians, please

Aug 7, 1947 ✓ MEDICAL CERTIFICATION

20. DATE OF DEATH 8-11 1947 at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-18 1947 to 8/11 1947. and that I last saw her alive on 8/10 1947.

Immediate cause of death	Duration
arterio-sclerotic cardiac disease	sev. yrs.
Due to	
Due to	
Other Conditions diabetes mellitus. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Rayner Browne M.D.
Address 1500 E. Madison St. Date signed 8/13/47

Rayner Browne 937

G51248

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G51248 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4159 FAIRVIEW AVE
(c) Hospital or institution: 28
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 36 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA DICKMAN

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife SOLOMON
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace RUSSIA (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name BERLE
13. Birthplace RUSSIA

MOTHER
14. Maiden Name DORA
15. Birthplace RUSSIA

16 (a) Informant JACK TURBOSKI
(b) Address 4161 FAIRVIEW AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-13-47 (month) (day) (year)
(c) Cemetery or crematory ROSEDALE
Location Phila Rd + Hamilton Ave

18 (a) Funeral director JACK LEWIS INC
(b) Address 2100 EUTAW PL.

AUG 13 1947 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-12 1947, at 1:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1946, to Aug. 12 1947, and that I last saw h[illegible] alive on Aug. 11 1947.

Immediate cause of death Generalized carcinomatosis — Duration 5 Mo.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature A. L. Pilson M. D.
Address Tuckahoe Gardens Golf · Date signed 8-[illegible]-47

PLEASE WRITE PLAINLY. Physicians: please write the cause of death so that correct age is especially important.

VS 150

G54249

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G54249 Registered No.

83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4110 Boarman Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 10
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4110 Boarman Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hannah Blumberg

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Adel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Solomon

13. Birthplace Russia

MOTHER 14. Maiden Name Sarah

15. Birthplace Russia

16 (a) Informant David Blumberg

(b) Address 3325 Piedmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-47 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Philp Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 2100 Eutaw Place

19 (a) (Date received by registrar) Huntington Williams, M.D.

AUG 13 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-13 1947, at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1947 to Aug. 13, 1947 and that I last saw h[illegible] alive on Aug. 13, 1947.

Immediate cause of death: Cerebral hemorrhage — Duration: 1 day

Due to

Due to

Other Conditions: Hypertension Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Nathaniel Shpritz M.D.

Address 1810 Eutaw Pl. Date signed 8/13/47

PLEASE WRITE correct age is especially important. Physicians: please write the causes of death clearly,

X

G51250

BALTIMORE CITY HEALTH DEPARTMENT G51250 ✓

CERTIFICATE OF DEATH 937

Registered No.....

1. PLACE OF DEATH: D.O.A
(a) Baltimore City, Maryland
(b) Street address 1355 Woodyear St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 hr
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County [redacted]
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1355 Woodyear St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) **FULL NAME** Esther Poulson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years	Months	Days	If less than one day
73			..... hr. ..... min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Unobtainable

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Esther Lewis

(b) Address 1305 Woodyear St

17 (a) Burial (b) Date thereof 8/14/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arlington

Location Md

18 (a) Funeral director Geo. H. Kelly

(b) Address 1303 Pennsylvania Ave
Huntington Williams M.D.

19 (a) AUG 13 1947 (b) ..... Registrar
(Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/12 1947, at 10:55 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V disease

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature C. J. Lambrake M.D.
Medical Examiner.
Date signed 8/15/47

X

G54251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G54251 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2730 Alameda
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2730 The Alameda
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GRACE L. REID

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband ~~or wife~~ Beverly R. Reid
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 25, 1881

8. AGE: Years	Months	Days	If less than one day
65	10	17	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Home
11. Industry or business

FATHER
12. Name Joseph Shaney
13. Birthplace Md.

MOTHER
14. Maiden Name Mary C. Linhard
15. Birthplace Balto. Md.

16 (a) Informant Mr. Beverly R. Reid
(b) Address 2739 The Alameda

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/47 (month) (day) (year)
(c) Cemetery ~~St. Agatha's~~ New Cathedral
Location Balto. Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North ~~Eutaw~~ Fayette Street Balto. 17, Md

19 (a) 1947 (b) Registrar
(Date received by registrar)

AUG 13

VS 150

MEDICAL CERTIFICATION

A

20. DATE OF DEATH Aug. 12, 1947, at 9:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] 19 46 to [illegible] 19 47
and that I last saw h[illegible] alive on [illegible] 19 47

Immediate cause of death (a) [illegible] Duration 7 yrs

Due to [illegible] 1 yrs

Due to [illegible]

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed [illegible]

X

Correct age is especially important. Physicians: please write.

G54252

BALTIMORE CITY HEALTH DEPARTMENT G54252 Registered No.

CERTIFICATE OF DEATH 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green Sts.
(c) Hospital or institution: University Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2601 Pennsylvania Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Meister CHARLES J. MEISTER

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary Emma Meister
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 22, 1869

8. AGE: Years	Months	Days	If less than one day
77	9	19	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Self
11. Industry or business

FATHER
12. Name Charles J. Meister
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth C. Reuter
15. Birthplace Md.

16 (a) Informant Mrs. Mary Emma Meister
(b) Address 2601 Pennsylvania Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D.

AUG 13 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/11 1947, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/8/47 19 to 8/11 1947, and that I last saw h.i.w. alive on 8/11 1947.

Immediate cause of death	Acute myocardial infarction	Duration
Due to		
Due to		
Other Conditions	Arteriosclerotic C.V.D.	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. D. Rhoads M. D.
Address University Hosp. Date signed 8/14/47

X

correct age is especially important. Physicians, please

G54253

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G54253

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1346 Sergeant St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 59 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1346 Sergeant St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AUGUSTA KLEIN

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband ~~or wife~~ August Klein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 29, 1865

8. AGE: Years	Months	Days	If less than one day
81	9	21	3 hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Martin Schneider
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mr. Gustav Klein
(b) Address 2900 Manhatta n Ave. 15

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/47 (month) (day) (year)
(c) Cemetery or ~~crematory~~ St. Paul Cem.
Location Violetsville, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

19 (a) Aug 13 1947 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11, 1947, 2:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1946 to Aug 11 1947 and that I last saw h~~e~~r alive on Aug 4 1947.

Immediate cause of death	Duration
Myocarditis chronic	2 years
Due to Arteriosclerosis	5 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John P. Ulrich, Jr. M. D.
Address 122 N. Wash. Blvd. Date signed 8/11/47

X

Please write correct age is especially important. Physicians, please write plainly.

G51254 Britton Snead ✓ G51254

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

102

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1515 Division St.
(c) Hospital or institution: Provident 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 914 N. Arlington
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Britton Snead

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: N | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Lewis Snead
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1911

8. AGE: Years 36 | Months | Days | If less than one day hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Home Wife

11. Industry or business

FATHER
12. Name Joseph Thompson
13. Birthplace Virginia

MOTHER
14. Maiden Name Melinda Viene
15. Birthplace Virginia

16 (a) Informant Lewis Snead
(b) Address 914 Arlington Ave.

17 (a) Burial (b) Date thereof Aug 14, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location

18 (a) Funeral director Joseph L. Rys
(b) Address 1200 N. Eutaw St.
(c) Rec'd by registrar Huntington Williams, M.D. Registrar
8 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/10/47 19 at 2:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/8 1947 to 8/10 1947 and that I last saw h.e.w. alive on 8/10 1947.

Immediate cause of death: (a) Uremia
(b)
Due to: Malignant Hypertension

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Paxton Grant
Address 1515 Division Date signed 8/10/47

PLEASE WRITE PLAINLY. Physicians: please write the correct age is especially important.

VS 150

X

G51255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G54255 Registered No. 137a

1. PLACE OF DEATH: Provident Hosp
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Calvert
(c) City or town Plum Point
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willie Buck.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	M

6 (b) Name of husband or wife Lillian Buck
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) August 1 [illegible]

8. AGE: Years	Months	Days	If less than one day
52 6-3	11	27	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Labor
11. Industry or business

FATHER
12. Name James Buck
13. Birthplace md

MOTHER
14. Maiden Name Rebecca Skinner
15. Birthplace md

16 (a) Informant Lillian Buck
(b) Address Owings md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-47 (month) (day) (year)
(c) Cemetery or crematory Asbury Chapel
Location Calvert Co

18 (a) Funeral director T E Sewell
(b) Address Prince Frederick Md

AUG 13 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/11/47 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 , and that I last saw him alive on 8/11 19 47.

Immediate cause of death: Hypertensive Heart Dis
Due to: & Chr. Nephritis
Due to:
Other Conditions: Hypertrophied Prostate
(Include pregnancy within 3 months of death)
Date of operation 8/7/47
Major findings of operation: Hypertrophied Prostate Suprapubic Op
Findings of autopsy: None.

Duration
.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
Signature Wm Coleman M.D.
Address Provident Hosp Date signed 8/13/47

PLEASE WRITE PLAINLY. Physicians: please write carefully. Exact age is especially important.

VS 150

G54256 — 42639s — 314

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

128 — G54256 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Kent
(c) City or town Worton (If outside city or town limits, write RURAL and give town)
(d) Street No. Route 47 Box 29 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Aaron Bright

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Daisey Bright

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) 8-1-79

8. AGE: Years 68 67 | Months - | Days 12 | If less than one day ... hr. ... min.

9. Birthplace Md (Town, county and state)

10. Usual Occupation Farm Labor

11. Industry or business

FATHER — 12. Name Thomas Bright

13. Birthplace Md

MOTHER — 14. Maiden Name Louise Cork

15. Birthplace ?

16 (a) Informant records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 17 '47 (month) (day) (year)

(c) Cemetery or crematory Fountain, Md.

Location Kent County R.F.D. Chestertown

18 (a) Funeral director B.R. Fellows

(b) Address Still Pond, Md

19 (a) ... (b) ...

Received by registrar ... Registrar's signature for Williams, M.D.

AUG 13 1947

VS 155

Correct age is especially important. Physicians: please write plainly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug-13- 1947 at 6 45 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-2- 1947 to 8-13- 1947 and that I last saw h alive on 8-13- 1947.

Immediate cause of death: Uremia — Duration:

Due to following

Due to Operation for Pancreatitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7/24/47

Major findings of operation? Chronic Pancreatitis

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ... at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Thomas N P Johns

Address Johns Hopkins Hosp Date signed 8/13/47

X

G51257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164a

G51257
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5259 Nelson Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH HOER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 19, 1882

8. AGE: Years	Months	Days	If less than one day
64	11	22	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ? Frederick
13. Birthplace Germany

MOTHER
14. Maiden Name ? ———
15. Birthplace Germany

16 (a) Informant Mr. William Hoer
(b) Address 5259 Nelson Avenue

17 (a) Burial (b) Date thereof Aug 14/1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Pk
Location

18 (a) Funeral director Henry H Wetzke
(b) Address 4141 Edmondson Ave
Huntington Williams, Md

19 (a) AUG 12 1947 Registrar
(Date received by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11, 1947, at 2 P. M

21. I certify that I took charge of the remains described above, held an insp.& inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Hanging

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-11-47 at 1.15 p. M.
(b) Where did injury occur? 5259- Nelson Ave. Balto. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury From bannister by rope

23. Signature Howard J. Mruzek M.D.
Medical Examiner.
Date signed 8-11-47

51258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

+ 10 8 ✓

Registered No. G51258

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Edwood Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna. (b) County
(c) City or town Philadelphia (If outside city or town limits, write RURAL and give town)
(d) Street No. 415 Carmack St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Willie Brett ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1906

8. AGE: Years 47 | Months | Days | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER 12. Name Lazarus James.
13. Birthplace Virginia

MOTHER 14. Maiden Name Fannie Melinda
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School AUG 13 1947

18 (a) Funeral director Commissioner of Health
(b) Address
(By) Hunter Van Williams M.D. Registrar
AUG 13 1947 (Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4 1947 at 10:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-27 1947 to 8-4 1947, and that I last saw h/M alive on Aug 4 1947.

Immediate cause of death Autopsy Congestion + Edema

Due to Pneumonia, left lower lobe

Due to

Other Conditions Bron. Ca. lung c metastasis to liver

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Calvin B Harris M. D.
Address University Hosp. Date signed 8-4-47

VS 150

X

correct age is especially important. Physicians, please

G51259

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Feike ✓ Registered No. G51259 940

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1915 Homewood av
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1915 Homewood av (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry P. Feike

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Geneviere
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23-1900

8. AGE: Years 47 | Months 2 | Days 19 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Auto Mech.
11. Industry or business Finish

FATHER
12. Name Harry A. Feike
13. Birthplace Md.

MOTHER
14. Maiden Name Hanna E Kelly.
15. Birthplace Md.

16 (a) Informant Geneviere Feike
(b) Address 1915 Homewood av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Fredrick Rd.

18 (a) Funeral director John R. Moran
(b) Address 1660 E. Balt. St. (18)

19 (a) Date received (by registrar) (b)

AUG 15 1947

V S 150

Thumbing for Hilleary Wright

Direct age is especially important. Physicians, please

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11th 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-8 1947, to 8-11 1947, and that I last saw h[illegible] alive on 8-11 1947.

Immediate cause of death	Duration
Coronary Thrombosis	4 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. D. Ryan M. D.
Address 11 E Chase St Date signed 8-13-47

X

G51260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1860

G51260 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 mos
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 639 W. Fayette st.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME May Nichols

3 (b) If veteran, name war N

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife George Nicholas

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 26th 1883

8. AGE: Years 63 | Months 8 | Days 16 | If less than one day .....hr. .....min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Joseph Prior
13. Birthplace Md.

MOTHER
14. Maiden Name Emma (Unknown)
15. Birthplace "

16 (a) Informant George Nichols
(b) Address 1829 McHenry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St.

19 (Date rec'd by registrar) AUG 13 1947 Huntington Williams, M.D. Registrar

correct age is uncertain

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/12 1947, at 10 30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Hypertension
Cardiovascular disease

Due to.....

Other Conditions Fracture of the left femur, intertrochanteric
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury 6-16-47 at 12:30 P.M.
(b) Where did injury occur? Washington Blvd & Fremont Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Fell to street while walking

23. Signature Earl K. Long M.D.
Medical Examiner.

Date signed 8-13-47

G51261

CWK-110541

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G51261

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 2-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Months
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1632 Thames Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Jessie Lambert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 25-1919

8. AGE: Years	Months	Days	If less than one day
28	3	17	hr. min.

9. Birthplace West Virginia
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Solomon Garber Lambert
13. Birthplace West Virginia

MOTHER
14. Maiden Name Ada Bennett
15. Birthplace West Virginia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/15/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Trinity
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (c) AUG 13 1947 (Date rec'd by registrar) (d) Huntington Williams, M.D.

correct age is especially important. Physicians, please

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH August 12 1947 at 9:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 9 1947 to Aug. 12 1947 and that I last saw h. in alive on Aug. 12 1947

Immediate cause of death	Duration
respiratory failure	3 da
Due to Tuberculosis of Lungs far advanced	9 mo +
Due to	
Other Conditions Emaciation - Anemia - Avitaminosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph J. Bowers Jr. M. D.
Address Balto City Hosp Date signed 8-13-47

G51262 Off p 76514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

24a

✓ G51262 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~1215 Tennant Way~~
(c) Hospital or institution: Mercy Hosp 26 b

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 wks
(e) Length of stay in Baltimore (yrs., mos., or days) 15 wks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1215 Tennent Way (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) **FULL NAME** Sharon Lee Russell

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 22/47

8. AGE: Years	Months	Days	If less than one day
	3	20	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation X
11. Industry or business

MOTHER / FATHER
12. Name Clayton V. Russell
13. Birthplace Balto Md
14. Maiden Name Frances Fiksak
15. Birthplace Balto Md

16 (a) Informant
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8/14/47 (month) (day) (year)
(c) Cemetery or crematory ST. STANISLAUS
Location BALTIMORE MD.

18 (a) Funeral director GEORGE W. LITTLE
(b) Address 2700 EDMONDSON AVE

AUG 13 1947 (b) Huntington Williams, M.D.
Date received by Registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13 1947 at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/1 1947 to 8/13 1947 and that I last saw her alive on Aug 13 1947

Immediate cause of death Septicemia — Duration 5 wks
Due to Staphylococcus infection
Due to
Other Conditions Secnd. Anemia over

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John B Buchanan M.D.
Address Mercy H. Date signed 8/13/47

PLEASE WRITE PLAINLY — correct age is especially important. Physicians, please

VS 150

54263 ✓ G54263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 24 S. Abington Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 24 S. Abington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward B. Gillece, Jr.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Married

6 (b) Name of husband or wife Dorothy E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 31, 1908

8. AGE: Years	Months	Days	If less than one day
38	9	11	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)
10. Usual Occupation Boat Builder
11. Industry or business U. S. Coast Guard

FATHER
12. Name Edw. B. Gillece
13. Birthplace Balto Md

MOTHER
14. Maiden Name Mary E. Timmons
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Dorothy E. Gillece
(b) Address 24 S. Abington Ave

17 (a) Burial (b) Date thereof Aug. 14/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Hampden-Balto. Md.

18 (a) Funeral director Harry H. Nitske
(b) Address 410 Edmondson Ave.

19 (Date rec'd by registrar) AUG 14 1947 Huntington Williams, M.D. Registrar

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 1947, at 3.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1945 to Aug 11, 1947, and that I last saw h him alive on Aug 11 1947.

Immediate cause of death: Recurrent carcinoma of colon — Duration: 2 years
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard Coppe M.D.
Address 310 W Baltimore St. Date signed 8/14/47 M. D.

PLEASE write correct age is especially important. Physicians, please

X

G54264

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 48 B

Registered No. G54264

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3615 Howard Park Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3615 Howard Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Maggie E. Robust

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife John R. Robust

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12, 1862

8. AGE: Years 85 | Months 5 | Days 1 | If less than one day hr. min.

9. Birthplace Woodlawn, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name James Brown
13. Birthplace Ireland

MOTHER
14. Maiden Name Elizebeth
15. Birthplace Pennsylvania

16 (a) Informant Mr. John Gates
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 15, 1947 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn Md.

18 (a) Funeral director E. Wilbur Lamoreau
(b) Address 4510 Liberty Heights Ave.

19 AUG 14 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

PLEASE WRITE PLAINLY. Physicians: please write correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1947, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h er alive on 19

Immediate cause of death: Carcinoma of Sternum — Duration: 4 months
Due to: Carcinoma of Breast — 10 years
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. C. Smith M.D.
Address 4509 Liberty Hgts Ave Date signed 8/13/47

G54265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓159

Registered No. G54265

Ch. 12743

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 17-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 Hrs. 20 Min.
(e) Length of stay in Baltimore (yrs., mos., or days) N.B. Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 517 Oxford (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Johnson (Elsie)

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 5 -1947

8. AGE: Years	Months	Days	If less than one day
			15 hr. 20 min.

9. Birthplace MD.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Johnson
13. Birthplace MD.

MOTHER
14. Maiden Name Elsie Jackson
15. Birthplace VA.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern AVE.

17 (a) Crematory (b) Date thereof 8-8-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern Avee

18 (a) Funeral director
(b) Address

19 (a) AUG 14 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150 Hospital Disposal

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 5 - 1947, at 3.50P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 5- 1947 to Aug.5 - 1947, and that I last saw her alive on Aug. 5- 1947.

Immediate cause of death	Duration
Prematurity (Wt = 11oz)	15 hrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Prematurity

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Julian P. Griffin M. D.
Address Balt. City Hosp. Date signed Aug 8 1947

X

Physician: Please be sure that the correct age is especially important. Physicians, please

G51266 L# 112775 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 159 Registered No. G51266

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 420 Colvin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Walker

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: C
6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug, 6-1947

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Charlie Walker
13. Birthplace Ga.

MOTHER
14. Maiden Name Daisey Lee
15. Birthplace Ga.

16 (a) Informant Records Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Crematory (Burial, cremation, or removal) (b) Date thereof 8-8-47 (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (a) AUG 14 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 6 1947, at 5:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 6 1947 to Aug 6 1947 and that I last saw h im alive on Aug. 6 1947.

Immediate cause of death	Duration
Prematurity (Wt=1 8oz)	1 day
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Prematurity

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Julian P. Griffin M. D.
Address Balt. City Hospitals Date signed Aug 8 1947

X

correct age is especially important. Physicians: please

~~51267~~ BALTIMORE CITY HEALTH DEPARTMENT G542677

CWK-111738 CERTIFICATE OF DEATH 1937 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 24 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Month
(e) Length of stay in Baltimore (yrs., mos., or days) 79 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 Sumwalt Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Charles Joseph Jones

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Roshl Jones (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15-1868

8. AGE: Years	Months	Days	If less than one day
79	5	27	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Thomas Jones
13. Birthplace West Virginia

MOTHER
14. Maiden Name Ann Folaton
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Cremation (b) Date thereof 8/14/47
(Burial, cremation, or removal) (month) (day) (year)
Burial
(c) Cemetery or crematory Colemanton
Location Colemanton, N.J.

18 (a) Funeral director Lilly & Zeiler Co.
(b) Address 463 N. Wolfe St.

19 (a) AUG 14 1947 Huntington Williams M.D.

correct age is especially important. Physicians, please

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH August 12 19 47, at 12:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 26 19 47, to Aug. 12 19 47, and that I last saw h im alive on Aug. 12 19 47.

Immediate cause of death	Duration
? Cerebral vascular accident	immediate
? Coronary Occlusion	immediate
Due to Hypertension C.V.D. and Arteriosclerotic H.D.	
Due to	
Other Conditions Generalized Arteriosclerosis Benign Prostatic Hypertrophy	?

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Balt City Hosp Date signed 8-13-47

54268 LW 112843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. G54268

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4040 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 5-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4 N. Caroline St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lloyd Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 7- 1892

8. AGE: Years 54 | Months 11 | Days 3 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Peter Harris
13. Birthplace Va.

MOTHER
14. Maiden Name Julia Anna Lockey
15. Birthplace Va.

16 (a) Informant Records Baltimore City Hospitals
(b) Address 4040 Eastern Ave.

17 (a) B B Burial (Burial, cremation, or removal) (b) Date thereof Aug 14 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery Cem
Location Brooklyn Md

18 (a) Funeral director Elroy D Wilson
(b) Address 1000 Brantley Ave

19 (a) (b) Registrar
AUG 14 1947 Washington Wilson, M.D.

VS 150

Print correct age is especially important. Physicians, please.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10 19 47 at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 8 19 47 to Aug. 10 19 47 and that I last saw him alive on Aug. 10 19 47

Immediate cause of death	Duration
Hepatic insufficiency	7
Due to Carcinoma metastatic of liver	
Due to Carcinoma, primary recto sigmoid Junction	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Carcinoma Recto Sigmoid c Metastasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Laurence Lee Jr M. D.
Address Balt City Hosp Date signed 8-12-47

1269

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

G51269 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 208 N. Amity St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Balto Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 208 Amity St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Taylor
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Co | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9 1849

8. AGE: Years 48 | Months 5 | Days 2 | If less than one day hr. min.

9. Birthplace Ala (Town, county, and state)

10. Usual Occupation H. H

11. Industry or business

FATHER 12. Name John Smith
13. Birthplace Ala

MOTHER 14. Maiden Name Millie Molley
15. Birthplace Ala

16 (a) Informant Sylvester Taylor
(b) Address 208 Amity Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 14 47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem Park
Location Baltimore County

18 (a) Funeral director Isaac L Brown Son
(b) Address 1084 Monroe Ave St Huntingdon Williamsport, Md

19 (c) AUG 14 1947 (Date received by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1947, at 3.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1946 to Aug 11 1947, and that I last saw her alive on Aug 10 1947.

Immediate cause of death Carcinoma of Uterus — Duration 9 Mos.
Due to C Metastasis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify kind of place)
(e) Means of injury

23. Signature Jos S Julian Jr M.D.
Address 516 W Saratoga St Date signed 8/13/47

PLEASE WRITE PLAINLY. Physicians: please write the correct age is especially important.

G51270 PURNELL

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G51270

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 923 Russel St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Purnell.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Henry Purnell
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Purnell
15. Birthplace Maryland.

16 (a) Informant Susanna Moore
(b) Address 107 Conway st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16 47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co. Md.

18 (a) Funeral director Isaiah L Brownlow
(b) Address 1088 Montgomery Street

19 (a) AUG 14 1947 Huntington Mill Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1947 at 3:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 6 1947 to Aug 12 1947 and that I last saw h/ alive on Aug 12 1947.

Immediate cause of death Uremia

Due to arteriosclerosis

Due to

Other Conditions Chronic Ca. stomach
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. B. Kearney M. D.
Address University Hosp. Date signed 8-12-47

Physician: please write correct age is especially important.

VS 150

X

G51271

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. G51271

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1512 S. Charles St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 S. Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Effert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Augusta
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3, 1870

8. AGE: Years	Months	Days	If less than one day
77	I	9	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Family
(b) Address 1512 S. Charles St.

17 (a) B (Burial, cremation, or removal) (b) Date thereof 8/15/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn, Md.

18 (a) Funeral director James L. McCarney
(b) Address 130 E. Fort Ave.

19 (a) AUG 14 1947 (Registered by registrar) Washington Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG. 12 1947, at 8 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from JULY 7, 1947, to AUG. 12 1947, and that I last saw HIM alive on AUG 11 1947.

	Duration
Immediate cause of death HYPOSTATIC PNEUMANIA	3 DAYS
Due to CHRONIC MYOCARDITIS AND MYOCARDIAL DEGENERATION-NOT RHEUMATIC	UNKOWN
Due to	
Other Conditions CHR. ULCERATIVE COLITIS	5 YEARS.

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation:
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James E Puterman M. D.
Address 1226 Hanover St Date signed 8/13/47

X

Please write clearly. Physicians: please write correct age is especially important.

51272

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C51272

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr
(e) Length of stay in Baltimore (yrs., mos., or days) 1 hr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Savage,
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ronald Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22,1927

8. AGE: Years	Months	Days	If less than one day
20	-	20	hr. min.

9. Birthplace Orange, Virginia
(Town, county, and state)
10. Usual Occupation Card stripper
11. Industry or business Cotton mill

FATHER
12. Name Samuel Thomas Smith
13. Birthplace Mason, Georgia

MOTHER
14. Maiden Name Lillian G. Whorton
15. Birthplace Unionville, Virginia

16 (a) Informant Lewis E. Smith
(b) Address Savage, Md

17 (a) Burial (b) Date thereof Aug.15,1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Savage, Cem
Location Savage, Md

18 (a) Funeral director DeWitt Donaldson
(b) Address Laurel, Md

19 (a) AUG 14 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

Correct age as expressed in figures.

VS 181

MEDICAL CERTIFICATION P.

20. DATE OF DEATH August 11, 1947, at 8:55 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were
IMMEDIATE CAUSE OF DEATH fractured skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-11-47 at 4:30 P M.
(b) Where did injury occur Baltimore Ave, Savage, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Fell from motorcycle when chain broke

23. Signature [signature] M.D.
Medical Examiner.
Date signed 8-11-47

51273

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. C51273

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1303 Penna Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 da 17-2
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 Penna Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife William Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 10, 1905

8. AGE: Years	Months	Days	If less than one day
42	6	-	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Alexander Thomas
13. Birthplace Md

MOTHER
14. Maiden Name Matilda Brundy
15. Birthplace Md.

16 (a) Informant William Jones
(b) Address 1303 Penna Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md

18 (a) Funeral director Geo. S. Kelson
(b) Address 1303 Pennsylvania Ave

AUG 14 1947 (Date received) (by) Huntington Williams, Md (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 10 1947, at 11 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 2 1947, to Aug 10 1947 and that I last saw h[illegible] alive on Aug 8 1947

Immediate cause of death Cardio Vascular Disease — Duration 7

Due to Pulmonary oedema — 8 days

Due to Obesity

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. W. Williams Trey M.D.

Address 1920 Pa Ave Date signed 8/14/47

PLEASE PRINT — correct age is especially important. Physicians: please write clearly.

VS 150

51274

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

Registered No. C51274

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 Park Ave.
(c) Hospital or institution:
Wheeler Nursing Home 14-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 Park Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia S. Baugher

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1, 1862

8. AGE: Years	Months	Days	If less than one day
85	6	12	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Constantine Baugher
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Emily A. Bevan
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Lillian B. Chisolm
(b) Address Barnesville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/47 (month) (day) (year)
(c) Cemetery ~~Crematory~~ New Cathedral Cem
Location Balto. Md.

18 (a) Funeral director WM. J. TIEKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17. Md.

19 AUG 14 1947 (Date rec'd by registrar) Thurlington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 13, 1947, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 4 1947, to Aug 13 1947, and that I last saw her alive on Aug 13 1947.

Immediate cause of death	Duration
chronic degenerative myocarditis	3 years +
Due to arteriosclerosis	
Due to	
Other Conditions mental degeneration; emaciation and dehydration	10 years +

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harlan L. Smith, Jr. M. D.
Address 1814 St Paul St. Date signed 8/13/47

X

Please see that correct age is especially important. Physicians: please

G54275

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G54275

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6308 Belair Road.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6308 Belair Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARTHA ELLEN ROEHNER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Charles H. Roehner
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) October 30, 1874

8. AGE: Years	Months	Days	If less than one day
72	9	12	..... hr. ..... min.

9. Birthplace ORIOLE, Somerset County, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business Housewife.

FATHER
12. Name John David Somers
13. Birthplace Somerset County, Md.

MOTHER
14. Maiden Name Martha Elizabeth Phoebus
15. Birthplace Wicomico County.

16 (a) Informant Ruby Somers
(b) Address 6308 Belair Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/15/47 (month) (day) (year)
(c) Cemetery or crematory Wesley Chapel Cem.
Location Rock Hall, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address 1604-4 Pa. Aves. Balto. 17, Md.

19 (a) AUG 14 1947 (Date rec'd by registrar) (b) Huntingtown Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1947, at 11.20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1947 to Aug 12 1947 and that I last saw her alive on Aug 12 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	3 weeks
Due to Hypertension cardio vascular disease	10 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Shelton O. Watson M.D.
Address 244 N. Milton Ave Date signed 8/15/47

correct age is especially important. Physicians, please

X

651276

651276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4114 Hamilton Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4114 Hamilton Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** ERNEST THEODORE QUAST

3 (b) If veteran, name war —

3 (c) Social Security Account No. 705-10-7469

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of ~~husband~~ wife Elsie Elizabeth Quast

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 26, 1891

8. AGE: Years 56 | Months 5 | Days 16 | If less than one day ... hr. ... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Chief Clerk

11. Industry or business Western Md. R. R.

FATHER
12. Name Ernest Louis Quast
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Harry C. Quast,
(b) Address 2810 Oakley Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/15/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

19 (a) AUG 14 1947 (Date rec'd by registrar) (b) Huntington Wilson Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/12/47 19... at 8:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy/Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Ward M.D.
Medical Examiner.
Date signed 8/13/47

542777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 542777

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 Whitelock St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1100 W. Whitelock St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John McCoy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Male	Colored	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/2/1878

8. AGE: Years	Months	Days	If less than one day
68	9	10	hr. min.

9. Birthplace Northumberland Co. Va.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Geo. McCoy
13. Birthplace Va.

MOTHER
14. Maiden Name Patty ?
15. Birthplace Va.

16 (a) Informant Mary Brooks
(b) Address 1616 Madison Ave

17 (a) Shipped (b) Date thereof 8/13/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lively Hope
Location Northumberland Co., Va.

18 (a) Funeral director William G. Jackson
(b) Address 2160 Penna. Ave

19 (AUG 14 1947 Huntington Williams M.D.
Date rec'd by registrar Registrar

Correct age if supplied.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1947, at 11 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy ~~or Inquiry~~ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 8-12-47

X

51278 Williams Estate

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G51278 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3519 Heyward Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1604 Greenmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles A. Knight

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-24-8486

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	W

6 (b) Name of husband or wife Carrie Porter Knight
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1881

8. AGE: Years	Months	Days	If less than one day
66	1	28	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Janitor Roland Pk. School

FATHER
12. Name John T. Knight
13. Birthplace Baltimore

MOTHER
14. Maiden Name Elizabeth A. Gregory
15. Birthplace Baltimore

16 (a) Informant Mrs. Maggie M. Hurley
(b) Address 3519 Heyward Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-15-47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Lazing Bybee
(b) Address 5505 Park Heights Ave

19 (Date rec'd by registrar) AUG 14 1947 (Registration No.) Baltimore, Md.

Please write clearly—correct age is especially important. Physicians: please write clearly—correct age is especially important.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13 1947, at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1947, to Aug 13 1947, and that I last saw h[illegible] alive on Aug 12 1947.

Immediate cause of death Myocarditis — Duration 2 Mo
Due to Bronchitis
Due to Senility
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy Nil

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Charles A. Wells M. D.
Address 5275 Park Heights Ave Date signed Aug 13, 47

1277 Transcript

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. G51279

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3412 Menlo Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3412 Menlo Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie L. Herbst.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	W.

6 (b) Name of husband or wife Charles E. Herbst
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1881

8. AGE: Years	Months	Days	If less than one day
66	1	20	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name William C. Norris
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Elizabeth Lovell
15. Birthplace Baltimore Maryland

16 (a) Informant Mrs. Elizabeth McShane
(b) Address 3412 Menlo Drive.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Loving Byers
(b) Address 5005 Park Heights Ave

19 AUG 14 1947 (Date rec'd by registrar) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/12 1947, at 3:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/10 1945, to 8/12 1947, and that I last saw h[illegible] alive on 8/12 1947.

Immediate cause of death Cardio-Renal-Vascular disease
Cardiac failure — Duration

Due to

Due to

Other conditions Subtotal Uterus-C
Malignancy
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hubert Burley M. D.
Address 1 W. Madison Date signed 8/14/47

PLEASE WRITE correct age is especially important. Physicians: please write legibly

VS 150

51280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (1937)

Registered No. G51280

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2502 Eutaw Place
(c) Hospital or institution: 13-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2502 Eutaw Place (If no street, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES WILMER DUNN

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 216-01-0328

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Mary Chapple Dunn
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.): March 12, 1885

8. AGE: Years	Months	Days	If less than one day
62	5	--	hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Superintendent
11. Industry or business: Apartment House

FATHER
12. Name: Frank Dunn
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Elizabeth
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. Mary Chapple Dunn
(b) Address: 2502. Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 16/47 (month) (day) (year)
(c) Cemetery or crematory: Cathedral
Location:

18 (a) Funeral director: Chas. J. Graves & Son Inc.
(b) Address: 118 W. Mt. Royal Ave.

19 AUG 14 1947 (Date rec'd by registrar) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 12 1947, at M

21. I certify that death occurred at the date above stated, that I attended deceased from April 6th 1947, to Aug 12th 1947, and that I last saw h[illegible] alive on Aug 12th 1947.

Immediate cause of death: Status Asthmaticus
Due to: Chronic Bronchial Asthma
Other Conditions: Hypertrophy Arteriosclerosis Myocardial Insufficiency
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration: 3 months / 10 months / Months

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work
(e) Means of injury:

23. Signature: Huntington Williams M.D.
Address: 118 W. Mt. Royal Ave. Baltimore 17, Md. Date signed: 8/13/47

Please write plainly; correct age is especially important. Physicians, please write carefully.

VS 150

G51281 G51281

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 49a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address /
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto Co.
(c) City or town Turners Sta.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 216 Sellers Pk. Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Tynes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

Sex: Female | 4 Color or race: Colored | 5 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Vernon Tynes

6 (c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.) 9-19-99

8. AGE: Years 47 | Months 10 | Days 23 | If less than one day ___ hr. ___ min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Bracy
13. Birthplace Va.

MOTHER
14. Maiden Name Mamie Diggs
15. Birthplace Va.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Aug 16/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A. 9 County Road
18 (a) Funeral director Mrs Ruth O. Elliott Est
(b) Address 1129 N. Carey St. Huntington Williams Mgr

19 (a) 1947 (b)
Filed by registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-12-47, at 10:13 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-17 1947 to 8-12-1947, and that I last saw her alive on 8-12 1947.

	Duration
Immediate cause of death: Leiomyoma of Uterus	1 mo
Due to:	
Due to: Hypertension	2 yrs
Other Conditions: Post Partum Hemorrhage	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature M. D.
Address Johns Hopkins Hosp Date signed 8/13/47

Effect age is especially important. Physicians, please write plainly.

VS 150

X

G51282

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G51282 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-3
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2342 Eutaw Place (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country.....

3 (a) FULL NAME Milton J. Burgunder

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Edna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-23-85

8. AGE: Years	Months	Days	If less than one day
61	9	21	....hr. ....min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER 12. Name Joseph Burgunder
13. Birthplace Md.

MOTHER 14. Maiden Name Theresa Gundersheimer
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/15/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto. Hebrew
Location Balto. Md.

18 (a) Funeral director Harris Sondheim & Son
(b) Address 902 Eutaw Place

AUG 14 1947 (Date received by Registrar) Huntington Williams, M.D. Registrar

V S 150

correct age is especially important. Physicians, please

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13, 1947, at 11 20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 8 1947, to Aug 13 1947, and that I last saw h.. alive on Aug 13 1947.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arteriosclerotic Heart Disease	
Due to	
Other Conditions Contributory or Predisposing (Include pregnancy within 3 months of death)	

Date of operation.....
Major findings of operation:.....
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at ....M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?....
(e) Means of injury.....

23. Signature [signature] M. D.
Address [illegible] Date signed 8-13-47

X

1283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. 0541283

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard & Madison Sts.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1505 Collington Ave #13 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Anna Bertha Arenda

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-09-4773

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR 15 1875

8. AGE: Years	Months	Days	If less than one day
72	4	28	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business R. Ret.

FATHER
12. Name Arend Arenda
13. Birthplace Germany

MOTHER
14. Maiden Name Ella LITTMAN
15. Birthplace Germany

16 (a) Informant Mabie Carpenter
(b) Address 1505 N. Collington Ave

17 (a) Burial (b) Date thereof 8-15-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location North Ave

18 (a) Funeral director John E. Miller Funeral Home
(b) Address 2433 Eastern Ave

19 AUG 14 1947 [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-12 1947 at 4:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-4 1947 to 8-12 1947 and that I last saw h[illegible] alive on 8-12 1947.

Immediate cause of death Generalized Lymphosarcoma — Duration

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation 8-5-47

Major findings of operation: Lymphosarcoma, right [illegible] of autopsy: Generalized Lymphosarcoma

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carlton Brumfield M. D.
Address Md. Gen. Hosp. Date signed 8-12-47

PLEASE WRITE PLAINLY. Information requested in items 1 to 19 is important. Physicians: please write the correct age is especially important.

VS 150

51281

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 694284

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) 0 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Crownsville (Rural)
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** MRS. ~~EMER~~ Edith Jane LANE

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Elmer F. Lane
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-22-'11

8. AGE: Years	Months	Days	If less than one day
35 36	11	8 2/3	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Turner R. Watson
13. Birthplace Maryland

MOTHER
14. Maiden Name Loula Upton
15. Birthplace Maryland

16 (a) Informant Elmer F. Lane
(b) Address [illegible]

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16 47 (month) (day) (year)
(c) Cemetery or crematory Baldwin Memorial
Location Sudbrook Md

18 (a) Funeral director [illegible]
(b) Address [illegible]

AUG 14 1947 (Registered by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-14 1947, at 3:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-24 1947 to 8-14 1947, and that I last saw her alive on 8-14 1947

Immediate cause of death Toxemia with Hyperpyrexia Prolonged — Duration 6 wk
Due to Typhoid Fever
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Typhoid fever

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Norman R. Freeman M.D.
Address Union Memorial Hosp. Date signed 8-17-47

correct age is especially important. Physicians, please

VS 150

1285 WANTKE

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. C51285

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 501 N Robinson St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 501 N. Robinson
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes C. Wantke.

3 (b) If veteran, name war —

(c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Widowed

6 (b) Name of husband or wife Edw Wantke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/12/1874

8. AGE: Years	Months	Days	If less than one day
73 72	6	-	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business at home

FATHER
12. Name Charles Hoyt
13. Birthplace Ireland

MOTHER
14. Maiden Name Katherine Hoyt
15. Birthplace Ireland

16 (a) Informant Mrs Lorette Hoke
(b) Address 501 N Robinson

17 (a) Burial (b) Date thereof Aug 16
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Rural

18 (a) Funeral director Ellis Funeral Home
(b) Address 210 E Oregon Dr

19 (a) AUG 14 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

V S 150

Correct age is especially important. If uncertain, say so.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1947, at 7 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to Aug 12 1947, and that I last saw h alive on Aug 12 1947

Immediate cause of death	Duration
CARCINOMA (UTERUS)	2 Yrs
Due to	
Due to	
Other Conditions PARTIAL OBSTRUCTION SIGMOID	1 Yr.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James F Kavanaugh M.D.
Address 3814 W Cold Spring Date signed 8-12-47

G51286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 106a

Registered No. G51286

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 110 N. Grecar St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Victoria Seekford

3 (b) If veteran, name war: None
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/1906

8. AGE: Years 0 | Months 11 | Days | If less than one day hr. min.

9. Birthplace Laurel, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Earl W. Seekford
13. Birthplace Sparks, Maryland

MOTHER
14. Maiden Name Dora Brooks Seekford
15. Birthplace Dalton, Georgia

16 (a) Informant Mrs. Dora B. Seekford
(b) Address 110 N. Green St, Balto., Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 17, 1947 (month) (day) (year)
(c) Cemetery or crematory Rileyville Cemetery
Location Page County Virginia

18 (a) Funeral director A. A. Eshenbaugh
(b) Address 5801 Cleveland Ave, Randalls, Md

19 (a) AUG 14 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/14 1947, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/14 1947 to 8/14 1947 and that I last saw h&s alive on 8/14/47 1947 at 2:50 AM

Immediate cause of death: Anoxia — Duration

Due to: Crushed Obstruction

Due to: Acute Serious Indian Bronchitis

Other Conditions: none noted

(Include pregnancy within 3 months of death)
Date of operation: none
Major findings of operation: none
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Burn Pratt M.D.
Address University Hosp. Date signed 8/14/47

Correct age is especially important. Physicians: please write plainly.

VS 150

Geo. Merrill MD

X

G51287

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered No. G51287

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Denison St
(c) Hospital or institution: Crawford Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 716 Lemard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Rumenap

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 18, 1885

8. AGE: Years	Months	Days	If less than one day
62	5	26	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name William Rumenap
13. Birthplace Germany

MOTHER
14. Maiden Name Louisa Rose
15. Birthplace Germany

16 (a) Informant Louisa Rumenap
(b) Address 716 Lemard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director Mrs. Jno. John W. Teufel Son
(b) Address 531 Edmondson Ave

19 (Date rec'd by registrar) AUG 14 1947 Huntington-Williams Mfg. Co.

PLEASE WRITE CLEARLY. Be sure to fill in correct age if especially important. Physicians: please write

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13 1947; at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 7 1947 to Aug 14 1947 and that I last saw alive on Aug 13 1947.

Immediate cause of death Edema of Lungs — Duration 2 days
Due to
Due to
Other Conditions Cerebral Hemorrhage — 1 mo
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature M. L. Lichtenberg M. D.
Address 108 E. Northar Date signed 8/14/47

VS 150

111c

51288

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 100 B

Registered No. G51288

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 865 Park Ave.
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County Russell
(c) City or town Castlewood (If outside city or town limits, write RURAL and give town)
(d) Street No. (Route 1) (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Henry Ernest Williams

3 (b) If veteran, name war None

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Victoria Williams

6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) June 3 1891

8. AGE: Years 56 | Months 2 | Days 10 | If less than one day hr. min.

9. Birthplace Castlewood - Va. (town, county, and state)

10. Usual Occupation Clerk (Food Fair)

11. Industry or business Foods

FATHER
12. Name Henry E. Williams
13. Birthplace Castlewood Va.

MOTHER
14. Maiden Name Virginia Gibson
15. Birthplace Castlewood Va.

16 (a) Informant Fred E. Williams Son
(b) Address 857 Hillman Ct.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug-14-47 (month) (day) (year)
(c) Cemetery or crematory Dulaney Valley Cem. Va.
Location Near Castlewood Va.

18 (a) Funeral director Stewart Mortuary Co.
(b) Address 1018 W. Lombard St.

AUG 14 1947 (Date rec'd by) registrar (Signature) for Williams M.D.

VS 150

correct age is especially important. Physicians, please

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13, 1947, at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 7, 1947, to Aug 13, 1947, and that I last saw him alive on Aug 13, 1947.

Immediate cause of death	Duration
Phlebitis of Right Leg - with Acute Cellulitis	2 days
Due to Acute arthritis 8/7/47 R. Knee Joint	6 days
Due to Phlebitis below R. Knee Joint 8/12/47 Rapid Extension	2 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. W. Kerwin M.D.
Address 1938 Linden Ave Date signed 8/13/47

G51289

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ G51289 — 85 — Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County St. Mary's
(c) City or town California
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Lee Tarleton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-8-41

8. AGE: Years	Months	Days	If less than one day
6	4	6	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Luther Tarleton
13. Birthplace Md

MOTHER
14. Maiden Name Mary Ridgell
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 8 / 16/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Face
Location Great Mills, Md.

18 (a) Funeral director W. L. Mattingley Son
(b) Address Leonardtown Md.

19 (a) 1947 (b)
(Date rec'd by registrar) Registrar

correct age is especially important. Physicians, please

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 1947, at 6 05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 21 1947 to Aug 14 1947. and that I last saw her alive on Aug 14 1947.

Immediate cause of death	Duration
CARDIO-RESPIRATORY FAILURE	
Due to ? ASPIRATION PNEUMONIA	
Due to DEGENERATIVE EPILEPSY (PARAHYDROMIC EPILEPSY)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation March 26th 1947
Major findings of operation: none
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William A. Spencer M. D.
Address Johns Hopkins Hosp. Date signed 8-15-47

V S 150 Huntington Williams, M.D. Harriet Lane X

G51290

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G51290 Registered No.

46E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkins & Caton Avenues
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Pasadena
(If outside city or town limits, write RURAL and give town)
(d) Street No. Magothy Beach
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Kusylis (Kvszlis)

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-8037

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1881

8. AGE: Years	Months	Days	If less than one day
66	9	12	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name
13. Birthplace Lithuania

MOTHER
14. Maiden Name
15. Birthplace Lithuania

16 (a) Informant Records (Putnaits)
(b) Address Magothy Beach

17 (a) Burial (b) Date thereof 8-16-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Charles W. Heckrotte
(b) Address 703 We Henry St

19 (a) 1947 (b) Registrar
Date received by registrar

Correct age is especially important. Explain any "Unknown"

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/12 1947 at 11:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/20 1947 to 8/12 1947 and that I last saw h. alive on 8/12 1947

Immediate cause of death Cardiac Failure

Due to Nutritional Deficiency - cachexia

Due to Generalized Carcinomatosis

Other Conditions Metastatic Nodules Lumbar - Sacral -
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: Generalized Carcinomatosis, &c

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sidney J. Venable Jr.

Address St Agnes Hospital Date signed M. D. 8/12/47

91

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered No. C51291

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Brunswick
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3022 Dartmouth
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Joan Moseley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-18-45

8. AGE: Years 1 | Months 22 | Days 27 | If less than one day ....hr. ....min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Wm. Moseley
13. Birthplace N.C.

MOTHER 14. Maiden Name Lillian Morton
15. Birthplace N.C.

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 8/16/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Jacksonville
Location Jacksonville, N.C.

18 (a) Funeral director Quinn Mc Bowen Co.
(b) Address Jacksonville, N.C.

AUG 15 1947
(Date rec'd by registrar) (b) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14 1947, at 10:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 13 1947 to Aug 14 1947 and that I last saw h[illegible] alive on Aug 14 1947.

Immediate cause of death	Duration
Cardiac Failure	2 weeks
Due to ? Intracath Bacterial Endocarditis	2 weeks
Due to Congenital Heart Disease	Life
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature P Brewer M. D.
Address John Hopkins Hosp Date signed 8-14-47

correct age is especially important. Typewriter preferred.

1292

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G51292

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2009 N Bentalou St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2009 N Bentalou St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph E. Gerhardt

3 (b) If veteran, name war

3 (c) Social Security Account No. Married

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Estelle

6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1870

8. AGE: Years	Months	Days	If less than one day
76	11	0	hr. min.

9. Birthplace Texas
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Ernst Gerhardt
13. Birthplace Texas

MOTHER
14. Maiden Name Lena Moxfelt
15. Birthplace Texas

16 (a) Informant Mrs Estelle Gerhardt
(b) Address 2009 N. Bentalou St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/15/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Frederick Ave

18 (a) Funeral director John F Denny Inc
(b) Address 716 Light St.

19 AUG 15 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13 1947, at 10:30 P.M.

21. I certify that I took charge of the remains described above, held an Aug 14 Aug Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to No death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J Helfrich M.D.
Medical Examiner.
Date signed Aug 14, 1947

correct if spelled as typed

54293 BC# B86896 BALTIMORE CITY HEALTH DEPARTMENT ✓ G54293
CWK-112899 CERTIFICATE OF DEATH 159 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 659 Pinrose Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Kemp, (Aline)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 10-1947

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Ernest Curtis
13. Birthplace Maryland

MOTHER
14. Maiden Name Aline Kemp
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Cremation (b) Date thereof 8-14-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Crematory
Location 4940 Eastern Avenue

18 (a) Funeral director
(b) Address

19 (a) AUG 15 1947 (b) Kathryn Williams, M.D.
(Date rec'd by registrar)

VS 150

correct age is especially important. Physicians, please

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1947, at 1:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 10 1947, to Aug. 12 1947, and that I last saw him alive on Aug. 12 1947.

Immediate cause of death	Duration
Atelectasis	2 days
Prematurity	2 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Prematurity, Atelectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Julian P. Giffin M. D.
Address Balt. City Hosps. Date signed 13 Aug. 1947

1294

CHK-107558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G51294

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution:

Baltimore City Hospitals 24

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Mos.

(e) Length of stay in Baltimore (yrs., mos., or days) 25 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1441 Summelt Court

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Harry Schneider

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15-1882

8. AGE: Years	Months	Days	If less than one day
65	-	20	hr. min.

9. Birthplace New York

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Jacob Schneider

13. Birthplace Germany

MOTHER

14. Maiden Name ?

15. Birthplace Germany

16 (a) Informant Records-Balto. City Hospitals

(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School AUG 12 1947

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) (Local registrar) AUG 15 1947 Huntington Williams M.D.

MEDICAL CERTIFICATION

A

20. DATE OF DEATH August 4 1947, at 10:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 13 19 47 to Aug. 4 19 47 and that I last saw h. in alive on Aug. 4 1947.

Immediate cause of death	Duration
Bronchopneumonia	
Due to	
Due to	
Other Conditions Paralysis agitans; Senile & Cerebral Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature H. K. Barbarow M. D.

Address Balto City Hosp Date signed 8-8-47

X

correct age is especially important. Physician please

VS 150

1295 G51295

BALTIMORE CITY HEALTH DEPARTMENT X ✓ Registered No.

BC# 685741 CERTIFICATE OF DEATH 159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. CHESTNUT
(c) Hospital or institution:
FRANKLIN SQUARE HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 mins.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Anne Arundel
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5343 Patrick Henry Pl. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JENNINGS

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-8-47

8. AGE: Years	Months	Days	If less than one day
			0 hr. 10 min.

9. Birthplace FRANKLIN SQUARE HOSPITAL (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name THEODORE PARRIL JENNINGS
13. Birthplace BRUNSWICK, MD.

MOTHER
14. Maiden Name IDA LUCERNE STORK
15. Birthplace BALT. MD.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

(Date rec'd by registrar) AUG 15 1947

University Medical School AUG 12 1947
Commissioner of Health
Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/8 1947 at 4:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/8 1947 to 8/8 1947 and that I last saw h[illegible] alive on 8/8 1947

Immediate cause of death CVD 10 —
HOSPITAL TO ITY Fd. 1 yr
Due to Immaturity

Due to

Other Conditions (Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide at M
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. Brinkshank
Address Franklin Square Hosp Date signed 8/8/47 M.D.

Please write plainly. Physicians: please write the correct age is especially important.

VS 150

X

1296

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30 B

Registered No. 8-54296

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 834 N. Eutaw St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarborne Avery

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife 3-22-86

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr) 3-22-86

8. AGE: Years 61 | Months 4 | Days 12 | If less than one day ___ hr. ___ min.

9. Birthplace Ga.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Clarborne Avery P

13. Birthplace

MOTHER 14. Maiden Name Nancy J. Sandifer P

15. Birthplace

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School

18 (a) Funeral director

(b) Address

(c) Date received by registrar AUG 15 1947 Huntington Williams M.D. Registrar

AUG 12 1947
Commissioner of Health

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-3 1947, at 4:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-30 1947 to 8-3-1947. and that I last saw h[illegible] alive on 8-3-1947.

Immediate cause of death general Paresis

Due to T. Palidum

Due to

Other Conditions Aortic Insufficiency

(Include pregnancy within 3 months of death)

Date of operation 8/3/47 - Craniotomy

Major findings of operation: Atrophic brain Fluid Not under pressure + sero

of autopsy: ———

Duration: Unknown

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas E. Van Metre Jr. M. D.

Address Johns Hopkins Hosp Baltimore Md Date signed 8/6/47

Correct age is especially important. Physicians: please write plainly.

VS 150

1297 JL - 112504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G51297

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 11 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 823 Bevans St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Hartman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Robert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 5, 1911

8. AGE: Years	Months	Days	If less than one day
36	5	27	hr. min.

9. Birthplace W. Va.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Ben Watson
13. Birthplace S. C.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address
(c) Date received by registrar AUG 15 1947

University Medical School AUG 12 1947
Commissioner of Health

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 2 1947, at 1:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 26 1947 to Aug. 2 1947, and that I last saw her alive on Aug. 2 1947.

Immediate cause of death	Duration
Meningitis, etiology undet. probably Tuberculous	? days
Due to Pulmonary Tuberculosis, right, minimal	? 11 months
Due to	
Other Conditions Hemiparesis, right and hemiplegia, etiol. undet	?

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Balt. City Hosps. Date signed 8-8-47

Respect age is especially important. Physician: please

VS 150

G51298

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G51298

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 7 days
(e) Length of stay in Baltimore (yrs., ~~mos., or days~~) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 417 Venable Ave (If rural give location)
(e) Citizen of foreign country? No (~~Yes or No~~)
If yes, name country

3 (a) FULL NAME Blanche A. Waldman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married, widowed,~~ or divorced.
female	white	widowed

6 (b) Name of husband or wife Harry C. Waldman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-15-77

8. AGE: Years	Months	Days	If less than one day
70	11	30	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John W. Portier
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary McWilliams
15. Birthplace Baltimore Md.

16 (a) Informant Allen E. Waldman
(b) Address 417 Venable Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/47 (month) (day) (year)
(c) Cemetery or crematory Forbush
Location Towsontown Md

18 (a) Funeral director Gilbert Colonial Funeral Home
(b) Address 1217 E. Fayette St

19 (a) (b)
(Date rec'd by registrar) AUG 15 1947 Registrar Huntington Williams, M.D.

VS 150

correct age is especially important. Physicians, please

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-14 1947, at 12:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-7 1947 to 8-14 1947 and that I last saw her alive on 8-14 1947.

Immediate cause of death Uremia — Duration 10 da.

Due to hypertensive cardiovascular disease — 7 yrs.

Due to glomerular nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Uremic nephritis.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman R. Freeman M.D.
Address Union Memorial Hosp. Date signed 8/17/47

1299 BC# B85745 BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161a ✓ Registered No. C51299

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 601 N. Broadway
(c) Hospital or institution:
The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town 2736 Bookert Drive Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2736 Bookert Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/9/47

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name J.C. Wilson
13. Birthplace Virginia

MOTHER
14. Maiden Name Helen Lee
15. Birthplace Virginia

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

AUG 15 1947 (Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 19 47 at 3.20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 9 19 47 to August 10 19 47, and that I last saw him alive on August 10 19 47.

Immediate cause of death — Duration

Atelectasis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature B.C. Williams M.D.
Address Johns Hopkins Hospital Date signed 8-11-47 M. D.

AUG 14 1947 Commissioner of Health

correct age is especially important. Physicians, please

X

G54300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

G54300
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2304 Madison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Theresa

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-16-12

8. AGE: Years	Months	Days	If less than one day
35	5	27	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation School teacher

11. Industry or business

FATHER
12. Name Joshua Thompson
13. Birthplace Md

MOTHER
14. Maiden Name Jenny Conegys
15. Birthplace Md

16 (a) Informant Resonda
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 16, 1947 (month) (day) (year)
(c) Cemetery or crematory Gorsuch Lane
Location Balto Co. Md

18 (a) Funeral director Wm. George Holland
(b) Address 681 Lombard East Ave

AUG 15 1947 Huntington Williams, M.D. Registrar
Date received by registrar

VS 150

correct age is especially important. Physicians, please

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1947 at 7 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 9 1947, to Aug 13 1947, and that I last saw him alive on Aug 13 1947.

Immediate cause of death	Duration
pulmonary edema	24 hrs.
Due to chronic glomerulo-nephritis	5 yrs.
Due to	
Other Conditions secondary anemia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. H. Sisson
Address Johns Hopkins Hosp. M. D.
Date signed Aug 13 47

51301 BCH D86207 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 182a ✓ G51301 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 913 W. Lexington St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, # 1 (If outside city or town limits, write RURAL and give town)
(d) Street No. 913 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jack Russell, Jr.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 4, 1947

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Jack Russell
13. Birthplace Portsmouth, Va.

MOTHER
14. Maiden Name Virginia Jones
15. Birthplace Norfolk, Va.

16 (a) Informant Virginia Russell
(b) Address 913 W. Lexington St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School

18 (a) Funeral director
(b) Address

19 (a) AUG 15 1947 (Date rec'd by registrar) Commissioner of Health Huntington Williams, M.D.

VS 150

PLEASE WRITE PLAINLY. Physicians: please fill correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5 1947, at 6:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7 Aug 1947, to 5 Aug 1947, and that I last saw h[illegible] alive on 4 Aug 1947

Immediate cause of death: cardiac failure

Due to: probable aspiration of vomitus from pickles in stomach

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide N/A
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allen D. Pate, Jr. M.D. c/c.
Address Univ. Hosp. Date signed Aug 7, 1947

X

1302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

Registered No. 651302

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1519 Rutland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1519 Rutland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Susan Guard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband ~~or wife~~ Edward F. Guard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1868

8. AGE: Years 78 | Months 11 | Days 6 | If less than one day hr. min.

9. Birthplace Fluvanna County Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John S. Wilkerson
13. Birthplace Va.

MOTHER
14. Maiden Name Susan C. Carver
15. Birthplace Va.

16 (a) Informant Edward F. Guard
(b) Address 1519 Rutland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 16 (month) (day) 1947 (year)
(c) Cemetery or crematory Baltimore Cemetery
Location North Ave

18 (a) Funeral director Leo G. Cook
(b) Address 1701-03 Patterson Pk. Ave.

19 (a) AUG 15 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

correct age is especially important. Physicians, please

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 14, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 10 1943 to Aug. 14 1947, and that I last saw h er alive on Aug. 13, 1947.

Immediate cause of death: Chronic Myocarditis — Duration

Due to: Arteriosclerotic Cardiovascular Disease. —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel W. Wolfe M. D.
Address 1331 E. North Ave Date signed 8-14-47

51303

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G51303

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2107 E. Federal St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2107 E. Federal St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Thomas

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Annie M. Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 19, 1873

8. AGE: Years	Months	Days	If less than one day
74	5	24	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Mill Worker
11. Industry or business

FATHER
12. Name William Thomas
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Baltimore Md.

16 (a) Informant Annie M. Thomas
(b) Address 2107 E. Federal St

17 (a) Burial (b) Date thereof Aug 16, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.
18 (a) Funeral director Leo G. Cook
(b) Address 1701-03 Patterson Pk. Ave
19 AUG 15 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

correct age is especially important. Physicians, please

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 August 1947, at 10:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 March 1947 to 23 July 1947, and that I last saw him alive on 23 July 1947.

Immediate cause of death	Duration
Myocardial Insufficiency	
Due to Left Ventricular Failure	10 months
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard Goldsmith M.D.
Address 1513 N. Milton Ave Date signed 14 Aug 47

X

51304 KRONEBERGER G51304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3733 Hanover
(c) Hospital or institution: Franklin Sq. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3733 Hanover St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrence Kronoberger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of ~~husband~~ or wife Katie Kronberger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 20, 1865

8. AGE: Years	Months	Days	If less than one day
82	6	25	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Charles Kronberger
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina Doerr
15. Birthplace Germany

16 (a) Informant Richard Kronberger
(b) Address 3733 Hanover St

17 (a) Burial (b) Date thereof Aug 18-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Edmondson Ave Balto.

18 (a) Funeral director Milton Schilling
(b) Address 3904 Hanover St

19 (a) AUG 15 1947 (b) Huntington Hilligoss, M.D.
(Date rec'd by registrar) Registrar

PLEASE WRITE PLAINLY. Physicians: please write correct age is especially important.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 Aug 19 47 at 1-35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8 Aug 19 47 to 14 Aug 19 47 and that I last saw him alive on 14 Aug 19 47

Immediate cause of death Hypostatic pneumonia

Due to

Due to

Other Conditions Fract. Femur

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 2577
(a) Accident, suicide, or homicide accident
(b) Date of occurrence Aug. 8th at A. M
(c) Where did injury occur? 3737 Hanover St.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Fell out of bed.

23. Signature H. A. Cacace M. D.
Address Franklin Sq. Date signed

H. H. Merrill MD Hosp. X 14 Aug 47

G51305 Etchieh

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 14

G51305 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Md. General Hospital
(c) Hospital or institution: Madison Ave & Linden St. ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 days
(e) Length of stay in Baltimore (yrs., mos., or days) -

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County -
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4436 Newport Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Francis Etchieh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Catherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/3/1883

8. AGE: Years	Months	Days	If less than one day
63	9	11	hr. min.

9. Birthplace Conn.
(Town, county, and state)

10. Usual Occupation Ret.

11. Industry or business

MOTHER / FATHER

12. Name -

13. Birthplace

MOTHER

14. Maiden Name -

15. Birthplace

16 (a) Informant Catherine L. Etchieh

(b) Address 4436 Newport Ave.

17 (a) Burial (b) Date thereof Aug 16, 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loraine Park

Location Wambaw Mill Rd.

18 (a) Funeral director Blenpenth Williamson

(b) Address 26(5047) Chestnut Ave

19 (a) AUG 15 1947 Huntington Williams, M.D.
Registrar

VS 150

PLEASE WRITE CLEARLY with pen and ink. Physicians: please write correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/14 1947 at 7:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/9 1947 to 8/14 1947, and that I last saw him alive on 8/13 1947.

Immediate cause of death. Respiratory failure — Duration

Due to Tubercular Compression of spinal cord

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7/16/47

Major findings of operation: Compression of cord 9th Thoracic Vert.

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature J. A. Mitchell M. D.

Address Md. Gen. Hosp. Date signed 8/17/47

1306 BALTIMORE CITY HEALTH DEPARTMENT G51306

TN. 112798 CERTIFICATE OF DEATH 48a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1155 N. Calhoun St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mildred Hill

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
? 26-30			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Not Known
13. Birthplace
MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School AUG 15 1947
18 (a) Funeral director Commissioner of Health
(b) Address
19 (a) Date received by registrar AUG 15 1947 (b) Registrar Hunter for Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9th. 1947, at 8.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 6th 1947 to Aug. 9th 1947 and that I last saw her alive on Aug. 9th 1947.

Immediate cause of death	Duration
Azotemia	
Anemia, and hypertensive encephalopathy	? ?
Due to Malignent Hypertension	
Due to	
Other Conditions Adenocarcinoma of Cervix (Include pregnancy within 3 months of death)	?

Date of operation 8-8-47 Biopsy of Cervix
Major findings of operation: Adenocarcinoma of cervix
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Balt. City Hosp. Date signed 8-14-47

correct age is especially important. Physicians, please

VS 150

307 LW 112507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30c

G54307 S-54307 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 242 Pearl St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theodore Blanford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10, 1901

8. AGE: Years	Months	Days	If less than one day
46	3	26	hr. min.

9. Birthplace Texas
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Fleta Hardee
15. Birthplace Texas

16 (a) Informant Records Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School AUG 15 1947

18 (a) Funeral director Commissioner of Health
(b) Address

AUG 15 1947 (Date rec'd by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 6-1947, 19..., at 7:40P M

21. I certify that death occurred on the date above stated; that I attended deceased from July, 26 1947, to Aug. 6 1947, and that I last saw h im alive on Aug. 6 1947.

Immediate cause of death	Duration
Meningitis, cause undet.	7 days
Probably	
Due to Central Nervous System Syphilis	
Due to Late latent syphilis	?
Other Conditions Gastrointestinal Hemorrhage, cause undet	10 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Balt. City Hosp. Date signed 8-14-47

correct age is especially important

VS 150

G51308

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G51308

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 40

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1518 Baker St
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Edgar Long, Jr.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M
5. Color or race Negro
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 10-7-1900
8. AGE: Years 46 Months 10 Days 0 If less than one day hr. min.
9. Birthplace Montgomery Ala.
(Town, county, and state)
10. Usual Occupation (an) Employed
11. Industry or business

FATHER
12. Name Edgar Allen Long
13. Birthplace Birmingham Ala.

MOTHER
14. Maiden Name Annie Lee Patterson
15. Birthplace Montgomery Ala.

16 (a) Informant Audrey Long Whitlock
(b) Address 619 Fairfax Rd Towson
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 15 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location
18 (a) Funeral director Joseph L. Russ
(b) Address 1200 McCulloh St.
AUG 15 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/6 1947 at M
21. I certify that death occurred on the date above stated; that I attended deceased from 8/5 1947 to 8/6 1947 and that I last saw him alive on 8/6 1947
Immediate cause of death 1(a) Bac Pneumonia — Duration 2 Days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Wm Garner
Address 1514 Division St Date signed 8/9/47

Please answer questions correctly and completely. Information is especially important. Physicians: please write

VS 150

51309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G51309

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 43 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 923 Burgundy St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Alt. Lebon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 30th 1888

8. AGE: Years	Months	Days	If less than one day
58	10	14	hr. min.

9. Birthplace Baltimore, Md. (Town, County and State)
10. Usual Occupation Lumber Wholesaler
11. Industry or business Sales

FATHER
12. Name Charles W. Le Bon
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Charlotte Whitefort
15. Birthplace Balto Md.

16 (a) Informant Mary C. Le Bon
(b) Address 923 Burgundy St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/13/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd.

18 (a) Funeral director John J. Curran & Son
(b) Address 96 & 03 Hollins St.

19 (a) AUG 15 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 19 47, at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 2, 19 47, to Aug 14 19 47 and that I last saw h. alive on August 14 19 47.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arteriosclerosis	
C-V disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. A. Waghorn M. D.
Address University Hosp Date signed 8-15-47

correct age is especially important. Physicians, please

51310

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

G51310 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1243- E. Pratt Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME STANLEY OSTROWSKI

3 (b) If veteran, name war

3 (c) Social Security Account No. 215074020

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Ostrowski

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 59 | Months | Days | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Longshoreman

11. Industry or business

FATHER
12. Name Adam Ostrowski
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace Poland

16 (a) Informant Mary Ostrowski
(b) Address 417 S Regester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 16/47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location: Baltimore

18 (a) Funeral director Fred W. Ozarowski
(b) Address 1930 Eastern Ave

19 (a) AUG 15 1947 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13, 1947, at 8.30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of skull
Intracranial hemorrhage
Contusion of brain
Edema of lungs

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 2/3

(a) Date of injury 8-13-47 at 8.50 A.M. Eastern Ave. & Anne St.
(b) Where did injury occur? Baltimore, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by truck

23. Signature Roger B. Merrill M.D.
Medical Examiner.
Date signed 8-14-47

VS 131

G51311 OC# B-63130

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G51311 Registered No. 13 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address HARFORD RD & HERRING RUN
(c) Hospital or institution: SYDENHAM HOSPITAL 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 8 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 538 McMechen ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS EUGENE JONES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	COLORED	SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 9. 1946

8. AGE: Years	Months	Days	If less than one day
	8	5	hr. min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name IRVINE JONES
13. Birthplace BALTIMORE MD.

MOTHER
14. Maiden Name EVA BILLIPS
15. Birthplace MARYLAND

16 (a) Informant IRVINE JONES
(b) Address 538 McMechen St. Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location [illegible] Co. Maryland

18 (a) Funeral director Harriman & Jackson
(b) Address 910 Penna Ave

19 (a) (Date rec'd by registrar) (b) Registrar
AUG 15 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 Aug. 1947 at 4.25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 28 Jul. 1947, to 14 Aug. 1947. and that I last saw him alive on 14 Aug. 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Meningitis, Tuberculous	3 wks
Due to Tuberculosis	
Other Conditions Tuberculosis, pulmonary, miliary, bilat	3 weeks

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ronald O. Cooper M. D.
Address Sydenham Hosp. Date signed 14 Aug 1947

correct age is especially important. Physicians, please

G51312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 36

G51312 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland HERRING RUN & HARFORD ROAD
(b) Street address
(c) Hospital or institution: SYDENHAM HOSPITAL 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3days
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 609 LINNARD ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN GILBERT ✓

3 (b) If veteran, name war: WORLD WAR II
3 (c) Social Security Account No.:

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: THELMA GILBERT
6 (c) If alive, give age 21 years
7. Birth date of deceased (mo., day, yr.) Feb. 2, 1923
8. AGE: Years 24 | Months 6 | Days 12 | If less than one day hr. min.
9. Birthplace BALTIMORE MARYLAND (Town, county, and state)
10. Usual Occupation SALESMAN
11. Industry or business HARDWARE STORE
FATHER 12. Name MARTIN J. GILBERT
13. Birthplace MARYLAND
MOTHER 14. Maiden Name GLADYS LILLY
15. Birthplace MARYLAND
16 (a) Informant THELMA GILBERT
(b) Address 609 LINNARD ST. BALTO MD.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16 1947 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson ave + Longwood (P
18 (a) Funeral director Harry H Wright
(b) Address 4101 Edmondson Ave Catonsville, Md
19 (a) L5 1947 (Filed by registrar) (b) Registrar

Correct age is especially important. Physicians, please cooperate.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14 1947, at 10 00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11 Aug 1947, to 14 Aug 1947, and that I last saw him alive on 14 Aug 1947.

Immediate cause of death: Respiratory failure — Duration: 9days

Due to: Poliomyelitis bulbar

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: Tracheotomy 13 Aug. 47

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Donald D. Johns M. D.
Address Sydenham Hosp. Date signed 14 Aug 1947

Cooper

4313

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

654313
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1134 Washington Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1134 Washington Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VERONICA SHRINER

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: GEORGE W.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14 - 1869

8. AGE: Years 78 | Months 10 | Days | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant GEORGE D. SHRINER JR.
(b) Address 1136 Washington Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 18-1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location City

18 (a) Funeral director Poff C. B. M. Walton
(b) Address Pratt & Stricker Sts

19 AUG 15 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

PLEASE FILL IN ALL ITEMS. Physicians: please write clearly. Accurate and correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 1947 at 11:43 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 21 1946 to Aug 14 1947. and that I last saw him alive on Aug 13 1947.

Immediate cause of death: Carcinoma of breast, right — Duration: 4 years

Due to

Due to

Other Conditions Diabetes Mellitus — 16 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John P. Unlock, Jr.
Address 1227 Wash Blvd Date signed 8/14/47 M.D.

X

51314

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered No. G51314

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3913 Fairview Ave.,
(c) Hospital or institution:
16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3217 Normount Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John George Young

3 (b) If veteran, name war ----

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Harriett E. Young
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17, 1855

8. AGE: Years	Months	Days	If less than one day
92	0	28	hr. min.

9. Birthplace New York, N. Y. (Town, county, and state)
10. Usual Occupation Credit Investigator
11. Industry or business Hecht Bros.

FATHER
12. Name Frank Young
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Mrs. Harriett E. Belitz
(b) Address 3217 Normount Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-18-47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore Co., Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.

19 AUG 15 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

correct age is especially important. Physicians, please

MEDICAL CERTIFICATION

2.30

20. DATE OF DEATH August 14, 1947 at p. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 5, 1947, to Aug. 14, 1947, and that I last saw h[illegible] alive on Aug. 14, 1947.

Immediate cause of death

	Duration
Cerebral Hemorrhage	10 days
Due to Nephritis & Arteriosclerosis	?
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Maurice L. Shamy, M.D.
Address 3300 W. Northern Date signed 8/15/47

1315

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 33B

Registered No. G51315

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Cecil
(c) City or town North East
(If outside city or town limits, write RURAL and give town)
(d) Street No. N. E. P. O.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Steve BOYD Lyons

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: Single
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-20-46

8. AGE: Years 0 | Months 9 | Days 25 | If less than one day ____ hr. ____ min.

9. Birthplace Md - (North East)
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Albert Lyons
13. Birthplace N.C.

MOTHER
14. Maiden Name Jay Belle David
15. Birthplace Okla.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.

18 (a) Funeral director E. Stewart & Monroe Company
(b) Address 1018 W. North Ave. City

19 (a) AUG 15 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

correct age is especially important. Typewrite or print plainly in ink.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14 1947, at 10 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 13 1947 to Aug 14 1947 and that I last saw him alive on Aug 14 1947.

	Duration
Immediate cause of death: Cardiac Failure	1 day
Due to: Influenza Pneumonia	4-5 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Duncan M. D.
Address Johns Hopkins Hosp. Date signed 8-14-47

1316

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G51316

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 117 N. Carlton St
(c) Hospital or institution:
18
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 117 N. Carlton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George A. Reid

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	married

6 (b) Name of husband or wife Jane Reid
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1884

8. AGE: Years	Months	Days	If less than one day
63	3 +	12	hr. min.

9. Birthplace Jamaica, B.W. Indies
(Town, county, and state)
10. Usual Occupation None.
11. Industry or business

FATHER
12. Name George Reid
13. Birthplace Jamaica, B.W.I.

MOTHER
14. Maiden Name
15. Birthplace B.W. Indies

16 (a) Informant Wolsley Reid
(b) Address 117 N. Carlton St

17 (a) Burial (b) Date thereof 8-16-1937
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary.
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) Filed AUG 15 1937 Huntington Williams, M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/13 1937, at 12 29 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1937 to 8/20/1937.
and that I last saw h(er) alive on 7/20 1937.

Immediate cause of death	Duration
Hypertensive Cardiac	2 yrs.
Due to	
Due to	
Other Conditions Malnutrition	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature L. Buxton Grant, M.D.
Address 1504 Division St. Date signed 8/16/37

correct age is especially important. Physicians, please

X

51317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (927)

Registered No. G51317

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 202 S. Exeter St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 202 S. Exeter
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Philip F. Liberto

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Maria Stella Liberto
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19 1875

8. AGE: Years	Months	Days	If less than one day
72	4	23 25	hr. min.

9. Birthplace Cefalu Italy
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name GianMaria Liberto
13. Birthplace Italy

MOTHER
14. Maiden Name Mariannina Giardina
15. Birthplace Italy

16 (a) Informant Joseph Bianca
(b) Address 212 S. Exeter St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 16 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.
18 (a) Funeral director Frank Della Vecchia
(b) Address 52 N. Morley St.
19 (a) AUG 15 1947 (Registrar's signature) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-13-1947, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-13-1947, to 8-13-1947 and that I last saw him alive on 8-12 1947.

Immediate cause of death Hypostatic pneumonia - — Duration 2 weeks
Due to Valvular disease of heart — years
Due to cardiac hypertrophy
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature S. D. Iacavelli M. D.
Address Medical Arts Bldg Date signed

Physician: please write correct age is especially important.

VS 150

Dr. Cole

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. G51318

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 650 S. Payson Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 650 S. Payson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY JOHN GETZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Lillian
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1889

8. AGE: Years	Months	Days	If less than one day
58	0	15	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Jacob Getz
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Atkins
15. Birthplace Md

16 (a) Informant Miss Frances Getz
(b) Address 650 S. Payson Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/47 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) AUG 15 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 12th, 1947, at 11 55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sep. 16, 1946 to Aug 12, 1947 and that I last saw him alive on Aug. 12 1947.

Immediate cause of death	Duration
Carcinoma of Cardiac end of stomach and lower end of esophagus	3 Yrs?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Oct 24, 1946
Major findings of operation: Inoperable Carcinoma
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alfred Cole
Address 1934 Wilkens Ave Date signed 8-13-47 (M. D.)

V S 150

correct age is especially important. registrar, please

51319

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 55E

Registered No. C51319

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore Co.
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 73 Northshire Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ORESTUS S. GLADFELTER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Sarah A. Gladfelter Deceased 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-11-68

8. AGE: Years	Months	Days	If less than one day
79	6	3	hr. min.

9. Birthplace Penna (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Albert Gladfelter
13. Birthplace Pa.

MOTHER
14. Maiden Name Sarah Klindist
15. Birthplace Pa.

16 (a) Informant Carl T. Gladfelter (Son)
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 16 1947 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Blvd.

18 (a) Funeral director Roland L. Fisher
(b) Address 2112 Dundalk Ave.

19 (a) AUG 15 1947 (Date rec'd by registrar) (b) Huntingtown Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-14-1947 at 12:47 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-10-1947 to 8-14-1947 and that I last saw him alive on 8-14-1947

Immediate cause of death	Duration
Carcinomatosis	14 Mos
Due to Epithelioma, Left face	4 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M.D.
Address 2213 Eyth Ave Date signed 8-14-47

Please write clearly—cause of death, etc., is especially important. Physicians: please write correct age

VS 150

54320 Rudolph J.C. Fleck.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 054320

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A
(b) Street address 2905 Hamilton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2905 Hamilton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rudolph J.C. Fleck

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1 - 1884

8. AGE: Years	Months	Days	If less than one day
63	2	12	hr. min.

9. Birthplace Genoa, Ohio
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Rev Charles F. Fleck
13. Birthplace Germany

MOTHER
14. Maiden Name Regina Kreichbaum
15. Birthplace Ohio

16 (a) Informant Miss Rosa F. Fleck
(b) Address 2905 Hamilton ave.

17 (a) Burial (b) Date thereof 8/15/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore Maryland

18 (a) Funeral director Fenard J. Reed
(b) Address 5305 Harford Rd

19 (a) AUG 15 1947 Huntington Williams, M.D.
(Date received by registrar) Registrar

Correct age is Opposite

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/14 1947, at 9:10 P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to h.s death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 8-15-47

X

CWK-113619

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V13B

Registered No. 954321

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 59 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1246 E. North Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Nowell

3 (b) If veteran, name war	3 (c) Social Security Account No.
(h)	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elsie Nowell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 2-1869

8. AGE: Years	Months	Days	If less than one day
77	8	13	hr. min.

9. Birthplace England
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Nowell (D)
13. Birthplace England

MOTHER
14. Maiden Name Catherine Jones (d)
15. Birthplace England

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/18/47 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore Md

18 (a) Funeral director Wilhelm Bros Inc
(b) Address 2174 E Baltimore

19 (a) AUG 15 1947 Huntington Williams, M.D.
(Date received by Registrar) (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH August 15 1947, at 1:01 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 14 1947 to Aug. 15 1947, and that I last saw h. in alive on Aug. 15 1947.

Immediate cause of death	Duration
Pulmonary Hemorrhage	
Due to Pulmonary Tuberculosis, left, with Cavita-	
Due to tion	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy As Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank L. Lassen
Address Baltimore City Hosp Date signed 8/15/47 M.D.

Parrott. X

Please correct age is especially important. Physicians, please write plainly.

G51322

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G51322 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 131 S. Morley St (29)
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (29)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 131 S. Morley St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Garvey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/18/1890

8. AGE: Years 57 | Months 2 | Days 25 | If less than one day ..... hr. ..... min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Michael Garvey
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Caffrey
15. Birthplace Ireland

16 (a) Informant Thomas Garvey
(b) Address 131 S. Morley St.

17 (a) Burial (b) Date thereof 8-16-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director George A Farley
(b) Address Baltimore and Fayette Sts

AUG 15 1947 (Date filed by Registrar) Thyntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG 12 1947, at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from MARCH 1946, to AUG 12 1947, and that I last saw her alive on Oct 1946.

Immediate cause of death	Duration
(a) Cerebral Hemorrhage	2 hrs
Due to (b) Hypertensive C.V.D.	years
Due to (c) Arteriosclerotic C.V.D.	years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. T. Lisowsky M. D.
Address 321 Cathedral Date signed Aug 12

PLEASE WRITE plainly in ink. Physicians: please correct age is especially important.

VS 150

G51323 G51323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5203 St. Charles Ave.
(c) Hospital or institution: 27

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5203 St. Charles Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie W. Parrish

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Horace E. Parrish
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 9, 1897

8. AGE: Years	Months	Days	If less than one day
49	11	4	hr. min.

9. Birthplace Cockeysville, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Allen
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie S. Babel
15. Birthplace Maryland

16 (a) Informant Mr. Horace W. Parrish
(b) Address 5203 St. Charles Ave.

17 (a) Burial (b) Date thereof Aug. 16, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Philbin & Cameron
Address 5 Washington Place, Md.
(b) AUG 15 1947
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1947, at 8.50P M

21. I certify that death occurred on the date above stated, that I attended deceased from 8/ 1947 to 8/14 1947
and that I last saw her alive on 8/12 1947

Immediate cause of death	Duration
Cancer of lungs	
Due to Cancer of breast	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.
Address 4710 Liberty Hgts Ave. Date signed

PLEASE WRITE correct age in especially important. Physicians; please

VS 150

#1324

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G51324

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5209 Bellville Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 8 Months

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5209 Bellville Ave (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Germany

3 (a) FULL NAME Camilla Bretenitz

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 19, 1870

8. AGE: Years	Months	Days	If less than one day
77	6	25	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER
12. Name Herman Jotnni
13. Birthplace Germany

MOTHER
14. Maiden Name — Leistner
15. Birthplace Reynstine, Germany

16 (a) Informant Mr. John F. Steinory
(b) Address 5209 Bellville Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory St. Stevens Cem.
Location Anne Arundel Co. Md.

18 (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie, Md.

19 AUG 16 1947 (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 3

correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/13 1947 at 9.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/29 1946 to 8/13 1947 and that I last saw h[illegible] alive on 8/13 1947

Immediate cause of death Gastric Cancer — Duration 8 mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Russell M. D.
Address 302 Goodwood Date signed 8/15/47

G54325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G54325

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2100 N. Charles St.
(c) Hospital or institution: ---
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ---
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2100 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? --- (Yes or No)
If yes, name country ---

3 (a) FULL NAME Eva A. Robinson

3 (b) If veteran, name war ---
3 (c) Social Security Account No. ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife ---
6 (c) If alive, give age ---years

7. Birth date of deceased (mo., day, yr.) Oct. 25, 1864

8. AGE: Years	Months	Days	If less than one day
82	9	18	---hr. ---min.

9. Birthplace Orange, Va.
(Town, county, and state)
10. Usual Occupation Retired Nurse
11. Industry or business ---

FATHER
12. Name Unobtainable
13. Birthplace Unobtainable

MOTHER
14. Maiden Name Unobtainable
15. Birthplace Unobtainable

16 (a) Informant Mr. James D. Robinson
(b) Address 2123 N. Charles St.

17 (a) Burial (b) Date thereof 8/16/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ######## New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. H. Mears & Son
(b) Address 805 N. Calvert St.

19 AUG 16 1947 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1947, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 1946, to August 13 1947, and that I last saw h[illegible] alive on August 13 1947.

Immediate cause of death: Coronary Thrust — Duration: Unknown

Due to ---

Due to ---

Other Conditions ---

(Include pregnancy within 3 months of death)

Date of operation ---

Major findings of operation: ---

of autopsy: ---

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ---
(b) Date of occurrence --- at --- M
(c) Where did injury occur? ---
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? --- While at work? ---
(Specify type of place)
(e) Means of injury ---

23. Signature Thos. R. Goodbody M. D.
Address 2923 N. Calvert St Date signed 8/15/47

Please answer all questions. Physicians: please correct age is especially important.

G54326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Register No. G54326

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkins Aves.
(c) Hospital or institution:
St. Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 17 Beaumont
(If rural give location)
(e) Citizen of foreign country? ---------- (Yes or No)
If yes, name country ----------

3 (a) FULL NAME Isabel Hardy

3 (b) If veteran, name war ----------
3 (c) Social Security Account No. ----------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife ----------
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
About 85	---	---	---- hr. ---- min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business ----------

FATHER
12. Name John D. Hardy
13. Birthplace England

MOTHER
14. Maiden Name Mercy Mark
15. Birthplace Virginia

16 (a) Informant E. Grace Hardy
(b) Address 17 Beaumont Ave.

17 (a) Burial (b) Date thereof 8/16/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ####### Green Mount
Location Baltimore, Md.

18 (a) Funeral director A. H. Mews and Son
(b) Address 805 N. Calvert St.

19 AUG 16 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 Aug 1947 at 9 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12 Aug 1947 to 14 Aug 1947 and that I last saw her alive on 14 Aug 1947.

Immediate cause of death	Duration
Myocardial Failure	
Due to Intestinal Obstruction	
Due to Annular Carcinoma Transverse Colon	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation } None
Major findings of operation: }
of autopsy: { Myocardial Failure; Intestinal Obstruction; Annular Carcinoma Transverse Colon

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. E. Groth M.D.
M. D.
Address St. Agnes Hosp Date signed 14 Aug 47

X

Please see that correct age is especially important. Physicians, please write

54327

CWK-112988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (937)

Registered G54327

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Hour
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3242 Foster Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Thomas Shanklin

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife Ida May -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21 - 1883

8. AGE: Years	Months	Days	If less than one day
64	0	23	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Tavern Keeper
11. Industry or business

FATHER
12. Name William Shanklin
13. Birthplace Md.

MOTHER
14. Maiden Name Marg. Alice Montgomery
15. Birthplace Md.

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/47 (month) (day) (year)
(c) Cemetery or crematory Waugh Chapel
Location Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

AUG 16 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

correct age is especially important. Physicians, please

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1947, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 13 1947, to Aug. 13 1947, and that I last saw him alive on Aug. 13 1947

Immediate cause of death	Duration
Acute Pulmonary Edema.	
Due to Hypertensive C-V Disease C.P.C.t	
Due to Hypertensive Encephalopathy	
Other Conditions ? Heat Exhaustion	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert R. Farber M. D.
Address Balto City Hosp. Date signed 8-16-47

This certificate to be approved by Medical Examiner Earle Riggin M.D.

54328

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓46E

Registered 54328

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline St.
(c) Hospital or institution: St. Josepha Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3311 Cliftmont Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Florence Bowling (IDA HEPLE BOWLING

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	Widowed

6 (b) Name of husband or wife: William F. Bowling Dead
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 29, 1882

8. AGE: Years	Months	Days	If less than one day
65	6	16	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Owns Home

FATHER
12. Name
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Kate Hebble
15. Birthplace Baltimore, Md.

16 (a) Informant Augustine M. Bowling
(b) Address 3311 Cliftmont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 18. 1947 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address Baltimore Md.

19 AUG 16 1947 (Date rec'd by Registrar) (Signature for William [illegible])

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 15, 1947 at 7:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/28/1947 to 8/15/1947 and that I last saw h[illegible] alive on 8/15/1947

Immediate cause of death Respiratory Failure — Duration
Due to Toxemia
Due to Abdominal Carcinomatosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Anthony F. DiPaula M.D.
Address St. Joseph's Hosp. Date signed 8/16/47

Please write plainly. Physicians: please write correct age is especially important.

VS 150

54329

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G54329

Registered No. 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2501 Harford Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2501 Harford Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MINERVA WILSON (MINERVA MARIE HANCOCK WILSON)

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife Samuel A. Wilson

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) June 15.1890

8. AGE: Years	Months	Days	If less than one day
57	1	29	....hr. ....min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles A. Hancock
13. Birthplace Maryland

MOTHER
14. Maiden Name Rachel R. Blunt
15. Birthplace Maryland

16 (a) Informant Dr. Samuel A. Wilson
(b) Address 2501 Harord Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 18. 1947 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address Baltimore Md.

19 (a) AUG 16 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 181

Correct age is important

MEDICAL CERTIFICATION P.

20. DATE OF DEATH August 14, 1947 at 3:55 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: ~~natural causes~~ ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Frye M.D.
Medical Examiner.
Date signed

54330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G54330

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 126-S. Hilton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 126-S. Hilton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine L. Feuerherd.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed.

6 (b) Name of husband or wife Adolph L. Feuerherd.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11-1889

8. AGE: Years 58 | Months 6 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore - Md.
(Town, county, and state)

10. Usual Occupation House Wife,
11. Industry or business At Home.

FATHER 12. Name John Grady.
13. Birthplace Germany.

MOTHER 14. Maiden Name Lena Richards.
15. Birthplace Md.

16 (a) Informant Mrs. Edward Feuerherd.
(b) Address 20-S. Bernice Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 18-47. (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location

18 (a) Funeral director Charles J. Schwab.
(b) Address 3512 Frederick Ave.

19 AUG 16 1947 (Date received by Registrar) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 1947, at 8.30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 22 1947 to Aug 14 1947, and that I last saw h[illegible] alive on Aug 11 1947

Immediate cause of death Cerebral hemorrhage | Duration 4 days

Due to Cerebral hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. McAleer M. D.
Address 3321 Frederick Date signed 8/14/47

Dr. X

PLEASE WRITE correct age is especially important. Physicians: please write plainly.

G54331

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1793

• Registered No. G54331

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital, Balto., Md. 12-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 days

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County France
(c) City or town Bourg de Plomodiern (If outside city or town limits, write RURAL and give town)
(d) Street No. (Finistere) (If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country France

3 (a) FULL NAME Albert Domart

3 (b) If veteran, name war --

3 (c) Social Security Account No. None

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Anne Marie Scordin Domart
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Sept. 4, 1923

8. AGE: Years 23 | Months 11 | Days 6 | If less than one day ..... hr. ..... min.

9. Birthplace France (Town, county, and state)

10. Usual Occupation .....

11. Industry or business Seafarer

FATHER
12. Name Maurice Domart
13. Birthplace France

MOTHER
14. Maiden Name Marie Brar
15. Birthplace France

16 (a) Informant Records
(b) Address U. S. Marine Hospital, Balto., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Bourg de Plomodiern
Location (Finistere) France

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) AUG 5 1947 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 1947, at 4:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1 1947 to Aug. 10 1947, and that I last saw him alive on Aug. 10 1947.

Immediate cause of death Nephrosis acute with uremia probably due to carbon tetrachloride — Duration: 10 Days
Due to toxemia
Due to .....
Other Conditions .....
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident 25/6
(b) Date of occurrence July 31 1947 at ..... M
(c) Where did injury occur? aboard ship S.S. Lauvia (City or town) Md. Dundalk (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? SS Lauvia (Specify type of place) While at work? Yes
(e) Means of injury Inhalation - Cleaning Tank

23. Signature C C Burford M. D.
Address U.S. Marine Hospital Date signed Aug 11 1947

Autopsy performed by Direction of H. A. Malkin M.D. Chief Medical Examiner

PLEASE WRITE PLAINLY. Correct age is especially important. Physicians: please write the causes of death

AS 150

G54332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G54332

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1228 Union Avenue
(c) Hospital or institution:
13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 59 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1228 Union Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anna R. Mullen

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12-1861

8. AGE: Years 86 | Months 3 | Days 2 | If less than one day hr. min.

9. Birthplace Frederick Co. Maryland
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name James F. Mullen
13. Birthplace Maryland

MOTHER
14. Maiden Name Martha E. Howard
15. Birthplace Maryland

16 (a) Informant Miss Mary F. Riley
(b) Address 1228 Union Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 18-1947 (month) (day) (year)
(c) Cemetery or Cemetery Location St. Marys Woods Baltimore, Md.

18 (a) Funeral director Dysart Funeral Home
(b) Address 3631 Falls Road

19 (Date rec'd by registrar) AUG 16 1947 (Signature of registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17-1947, at 9.50 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 7 1947, to August 17 1947, and that I last saw h[illegible] alive on 8-17 1947

Immediate cause of death Cerebral Hemorrhage — Duration 6 da

Due to Hypertension CVD — 2

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Laurence J. Linnard M.D.
Address 3[illegible] Falls Rd. Date signed 8-15-47

V S 150

X

Please write plainly. Physicians: please write correct age is especially important.

54333 BC# B-19583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 568

Registered No. G54333

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1422 Woodall St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 1422 Woodall St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Ed Melnick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16 - 1945

8. AGE: Years: 2 | Months: 5 | Days: 29 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Melnick
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Sophie Serpinska
15. Birthplace Balto. Md.

16 (a) Informant John Melnick
(b) Address 1422 Woodall St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-18-47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem
Location

18 (a) Funeral director John C Miller Inc
(b) Address 2435 E Oliver St

19 (a) AUG 16 1947 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-15-1947, at 11 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19.. to Aug 15 1947 and that I last saw h alive on Aug 8-15 1947.

Immediate cause of death	Duration
Tuma Brain	8 mo
Due to (a)	
Due to	over
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Dec 7th - 46
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Earle A Stevens M. D.
Address 2598 Harford Ave Date signed 8/15/47

Earle A Stevens MD

Please write plainly. Physicians: please write correct age is especially important.

54334

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G54334

CERTIFICATE OF DEATH

Registered No. 106a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Lombard & Greene Sts
(c) Hospital or institution: Bon Universal Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Sykesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DAVID HIGGS (Aaron)

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Wh	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12, 1945

8. AGE: Years	Months	Days	If less than one day
1	11	1	hr. min.

9. Birthplace Alexandria, La
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Paul HIGGS
13. Birthplace Grangate, Ind

MOTHER 14. Maiden Name Lottie Lois Burk
15. Birthplace Ark

16 (a) Informant Paul Higgs
(b) Address Sykesville, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16, 1947 (month) (day) (year)
(c) Cemetery or crematory Springfield
Location Maryland

18 (a) Funeral director Rita Weisenfeld
(b) Address 900 East Biddle St

19 AUG 16 1947 (b) Huntington Williamson, Md
(Date received by Local Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1947, at 1:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 12 1947 to Aug 13 1947, and that I last saw him alive on Aug 13 1947

Immediate cause of death: Cardio-respiratory failure — Duration
Due to: acute lobular atelectasis & pneumonia
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Jno Shea
Address Sykesville Md Date signed Aug 14 1947

VS 150

X

Physician is especially important. Physicians: please correct age is especially important.

54335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937 ✓

Registered No. G54335

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hampnett Ave.
(c) Hospital or institution:
Pine Ridge Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1649 Thomas Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles R. Stup

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife May Stup
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 22, 1868

8. AGE: Years	Months	Days	If less than one day
78	11	22	hr. min.

9. Birthplace Frederick, Md.
(Town, county, and state)
10. Usual Occupation Stationary Engineer Retired
11. Industry or business Empire Laundry

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Alice Brown
15. Birthplace Unknown

16 (a) Informant Mrs. Geo. P. Johnson
(b) Address 1179 California Rd.

17 (a) Burial (b) Date thereof 8/16/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Mausoleum
Location Woodlawn Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves.

19 AUG 16 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

correct age is especially important. Physicians: please

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14, 1947 at 4 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-14-47 1947, to 8-1 1947, and that I last saw him alive on 8-1 1947.

Immediate cause of death	Duration
Hypertensive Cardiovascular Disease	10 yrs.
Due to ?	
Due to	
Other Conditions Marked Arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. N. Drumheller M. D.
Address 14 E. Eager St Date signed 8/16/47

NS 150 This patient was pronounced dead by Dr. W. N. Drumheller who had seen him in consultation. He had never seen him before.

4336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G54336

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2107 N. Charles St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 2107 N Charles St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest A Weller

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Fonsia Wilson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1889

8. AGE: Years	Months	Days	If less than one day
57	10	24	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Conferee
11. Industry or business Internal Revenue Dept

FATHER
12. Name Alexander Weller
13. Birthplace Germany

MOTHER
14. Maiden Name Emma Ehrhardt
15. Birthplace Md.

16 (a) Informant Mrs. Ernest A. Weller
(b) Address 2107 N. Charles St.

17 (a) Burial (b) Date thereof 8/18/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Rd. Balto. Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves

19 (a) Date received by Registrar AUG 18 1947 (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15 1947, at 5:45 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J Kelsch M.D.
Medical Examiner.
Date signed Aug 15, 1947

54337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G54337
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1408 E Lanvale St.
(c) Hospital or institution:
—
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1408 E. LANVALE ST.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME SOPHIE LOLA MAULE

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife JOHN F. MAULE
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Nov. 6 1870

8. AGE: Years	Months	Days	If less than one day
76	9	7	....hr. ....min.

9. Birthplace HAMBURG, GERMANY
(Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Amelia Weiger
15. Birthplace 1408 E. Lanvale St.

16 (a) Informant FRANK R. MAULE – SON
(b) Address 508 BROADVIEW BLVD

17 (a) Burial (b) Date thereof 8/16/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~XXXXXXX~~ Baltimore
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address N. Pa. Aves. Balto. 17, Md.

19 (a) AUG 16 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 13 1947, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from AUGUST 7, 1947 to AUGUST 13, 1947, and that I last saw her alive on AUGUST 13 1947

Immediate cause of death	Duration
DEHYDRATION	1 WEEK
Due to INTESTINAL OBSTRUCTION	2 WEEK
Due to CARCINOMA OF STOMACH & METASTASIS TO LIVER	2 MONTHS
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Frederick J. Vollmer M. D.
Address 6100 York Rd-12 Date signed Aug 16, 1947

Please see that correct age is especially important. Physicians, please

X

54338

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44B

✓ G54338 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7112 Harford Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7112 Harford Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Agostino J. Capitano

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-16-9286

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of ~~XXXXXX~~ wife Mildred

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 4/18

8. AGE: Years 28 | Months 9 | Days 10 | If less than one day hr. min.

9. Birthplace Perryville Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Salvatore Capitano
13. Birthplace Italy

MOTHER 14. Maiden Name Maria Santa Piraino
15. Birthplace Italy

16 (a) Informant Mildred C. Capitano (Wife)
(b) Address 7112 Harford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 18 1947 (month) (day) (year)
(c) Cemetery or crematory Moreland Me. Park
Location Taylor Avé Baltimore Md.

18 (a) Funeral director Frank Della Rose
(b) Address 52 N. Morley St.

19 (Date rec'd by registrar) AUG 16 1947 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 Aug 1947, at 12 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to 14 Aug 1947 and that I last saw him alive on 14 Aug 1947

Immediate cause of death Hodgkins Disease — Duration 4 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.
Address 715 N. Charles Date signed 8/16/47

Please write clearly and correct age is especially important. Physicians: please write underline the cause to which death should be charged statistically.

VS 150

4339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

87E

Registered No. C54339

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert and 33rd Streets
(c) Hospital or institution: The Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Cuba (b) County
(c) City or town c/o Children Rehabilitation Institute (If outside city or town limits, write RURAL and give town)
(d) Street No. Cockeysville, Md (If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country Cuba

3 (a) FULL NAME Cecile B. Real

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: female

5. Color or race: white (Cuban)

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1941

8. AGE: Years 5 | Months 11 | Days 19 | If less than one day — hr. — min.

9. Birthplace Santiago, Cuba (Town, county, and state)

10. Usual Occupation Institutionalized for Rx of
11. Industry or business Cerebral Palsy

FATHER
12. Name Gabriel E. Real
13. Birthplace Cuba

MOTHER
14. Maiden Name Conselda Lopez de Real
15. Birthplace Mexico

16 (a) Informant Mrs. B. M. Wolpole
(b) Address Children's Rehabilitation Institute Cockeysville, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/47 (month) (day) (year)

(c) Cemetery or crematory Mount Cathedral Cemy.
Location Balto. Md.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place

19 (a) AUG 16 1947 (b) (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 14 1947 at 6:50 A M

21. I certify that death occurred on the date above stated: that I attended deceased from Aug. 13 1947 to Aug 14 1947.
and that I last saw h— alive on Aug 14 1947

Immediate cause of death Acute Pyelitis — Duration 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lakmir E. Young M. D.
Address Union Memorial Hospital Date signed 8/14/47

Please fill in all items carefully and correct age is especially important. Physicians: please

X

4340

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. C54340

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 47 days
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Mt. Washington Suburb
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2411 Everton Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Wolf

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Rev. Luther B. Wolf

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-16-55

8. AGE: Years 92 | Months 5 | Days 29 | If less than one day ..... hr. ..... min.

9. Birthplace Pa (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Josiah Benner
13. Birthplace Pa

MOTHER
14. Maiden Name Edith Norris
15. Birthplace Pa

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/18/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemy
Location Pikesville Md.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place

19 (a) AUG 16 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

AUG

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15 1947 at 4 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 28 1947 to Aug 15 1947, and that I last saw her alive on Aug 15 1947.

Immediate cause of death	Duration
Cerebro-vascular accident.	
Due to Arteriosclerosis.	5 yrs.
Due to	
Other Conditions Bronchopneumonia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: Not done.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. B. Marrow

Address JHH Date signed 8-15-47 M. D.

Please correct age is especially important. Physicians, please

9341 X E-66415

Med. Exam. Case

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

Registered No. C54341

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1121 Somerset, St. (If rural give location)
(e) Citizen of foreign country?..... (Yes or No) If yes, name country.....

3 (a) FULL NAME Melvin Poindexter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 12-29-46

8. AGE: Years | Months: 7 8 | Days: 16 | If less than one day: ..... hr. ..... min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER 12. Name Joseph Poindexter
13. Birthplace Va

MOTHER 14. Maiden Name Mary Edmonds
15. Birthplace N.C.

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Q. A. County Md

18 (a) Funeral director Mrs Robt A. Elliott & Dgt
(b) Address 1129 N. Caroline St

19 Aug 16 1947 Huntington Williams Md Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug-14-1947 at 4 09 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-13-1947 to 8-14-1947 and that I last saw him alive on 8-14-1947.

Immediate cause of death: Aspiration — Duration: minute

Due to Operation for

Due to Injured Uterus

Other Conditions.....

(Include pregnancy within 3 months of death)

Date of operation 8-14-47

Major findings of operation: Left Indirect Injured Uterus

of autopsy:.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Aspiration
(b) Date of occurrence 8-14-47 at 3 45 A.M.
(c) Where did injury occur? Balto Balto Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Hospital (Specify type of place) While at work? No
(e) Means of injury Aspiration during operation

23. Signature Mike Brown M. D.

Address Johns Hopkins Hosp. Date signed 8-14-47

Earl K. Rogers MD

correct age is especially important. Physicians: please

54342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G54342
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 644 Carey St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Calvin Gibson

3 (b) If veteran, name war —

3 (c) Social Security Account No. 214-14-3527

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Sep - Dead

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-25-20

8. AGE: Years 26 | Months 7 | Days 19 | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William Gibson
13. Birthplace Md.

MOTHER 14. Maiden Name Florence Day
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16 1947 (month) (day) (year)
(c) Cemetery or crematory St Mary Emmitsburg
Location A.C. Co. Md

18 (a) Funeral director Robt Gilliam
(b) Address 15 15 McElderry

19 (a) AUG 16 1947 (b) (Date received by registrar) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1947 at 9 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 5 1947 to Aug 13 1947 and that I last saw him alive on Aug. 12 1947.

Immediate cause of death	Duration
cardiac failure	24 hrs
Due to hypertensive cardio vascular disease	14 mo
Due to chronic interstitial nephritis	7 14 mo
Other Conditions hypertensive encephalopathy	1 mo

(Include pregnancy within 3 months of death)

Date of operation July 1946
Major findings of operation: lumbar dorsal sympathectomy
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. A. Lisson M. D.
Address Johns Hopkins Hosp. Date signed 14 Aug 47

correct age is especially important. Physicians: please

54343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48 B

Registered No. G54343

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1427 Pennsylvania Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1427 Pennsylvania Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Janie Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Lionel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1894

8. AGE: Years	Months	Days	If less than one day
52	11	6	hr. min.

9. Birthplace Fayetteville, N.C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry Mackey
13. Birthplace Fayetteville, N.C.

MOTHER
14. Maiden Name Annie Beale
15. Birthplace Fayetteville, N.C.

16 (a) Informant Mr. Lionel Johnson
(b) Address 1427 Pennsylvania Ave

17 (a) Burial (b) Date thereof Aug. 16, 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Wm. George H. Stafford
(b) Address 1631 Druid Hill Ave

19 (a) (b) Registered by Huntington Williams M.D.

AUG 16 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13 1947, at 4P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/10 1947 to 8/13 1947, and that I last saw h[illegible] alive on 8/13 1947.

Immediate cause of death	Duration
Carcinoma, uterus	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation none 1947
Major findings of operation: C.A. Corpus (Hopkins)
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George McDonald M. D.
Address 844 N. Carey Date signed 8/16/47

PLEASE WRITE correct age is especially important. Physicians: please write

G54344 BALTIMORE CITY HEALTH DEPARTMENT X ✓ G54347 No. 469

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37 days
(e) Length of stay in Baltimore (yrs., mos., or days) 37 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Prince George Co.
(c) City or town East Riverdale (If outside city or town limits, write RURAL and give town)
(d) Street No. 5509 Tanglewood (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME SAMUEL CLIFTON AUSTIN

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Virginia Austin
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) May 16, 1910

8. AGE: Years	Months	Days	If less than one day
37	3	0	— hr. — min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business —

FATHER
12. Name Nathan Austin
13. Birthplace Virginia

MOTHER
14. Maiden Name Emma Bowman
15. Birthplace Virginia

16 (a) Informant Virginia Austin
(b) Address 5509 Tanglewood Dr. East Riverdale Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 17/47 (month, day, year)
(c) Cemetery or crematory Hyattsville
Location " "

18 (a) Funeral director Ennis Eschelbrons
(b) Address Hyattsville Md.

AUG 17 1947 (b) (Date rec'd by Registrar) Registrar
Huntington Williams, M.D.

VS 150

Please write clearly — correct age is especially important. Physicians: please write

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16 1947, at 10:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 9 1947 to Aug 16 1947 and that I last saw him alive on Aug 16, 1947.

Immediate cause of death	Duration
cachexia	1 yr
Due to Carcinoma of Pancreas with metastases	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation July 16, 1947
Major findings of operation: Carcinoma Head of pancreas & metastases
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jack A. Gregory, Jr. M. D.
Address Union Mem. Hosp Date signed 8-16-47

G54345

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

Registered No. G54345

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3712 Columbus Drive
(c) Hospital or institution: 15 11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3712 Columbus Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Philip Bernhardt

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1888

8. AGE: Years 59 | Months 3 | Days 10 | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business Retired

FATHER
12. Name Samuel Bernhardt
13. Birthplace Russia

MOTHER
14. Maiden Name Hannah Gall
15. Birthplace Russia

16 (a) Informant Mrs Anna Bernhardt
(b) Address 3712 Columbus Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 17, 1947 (month) (day) (year)
(c) Cemetery or crematory Anshei Emunah Cong Cem
Location Washington Blvd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (Date received by registrar) (b) Huntington Williams, M.D.
AUG 17 1947

VS 160

MEDICAL CERTIFICATION 1.40

20. DATE OF DEATH August 16 1947 at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 8 1947, to Mar. 31 1947, and that I last saw him alive on Mar. 31 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension	
Due to Arteriosclerosis	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daniel J. Schwartz M. D.
Address 2320 Eutaw Place Date signed 8/16/47

83a

PLEASE WRITE THE CAUSES OF DEATH CLEARLY. Correct age is especially important. Physicians: please write legibly.

G54346 BCHF 35876

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

170 c

G54346 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2646 Matthews St (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Robert Parr

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 21/41

8. AGE: Years	Months	Days	If less than one day
5	11	14	..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name William Parr
13. Birthplace Baltimore

MOTHER
14. Maiden Name Corabelle Parr
15. Birthplace Baltimore

16 (a) Informant Mrs Jenkins
(b) Address 2646 Matthews St

17 (a) Burial (b) Date thereof Aug 18/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road

18 (a) Funeral director Geo M Trick Son
(b) Address 811 N Wolfe St

19 (a) Aug 17 1947 (b) Huntington-Holliday, M.D.
(Date rec'd by registrar)

Correct age is especially important

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-15-1947, at 11 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed chest, fracture of skull, fracture of left femur, fractured pelvis

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-15-47 at 11 A. M.
(b) Where did injury occur? In street in front of home
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Struck by truck

23. Signature [signature] M.D.
Medical Examiner.
Date signed 8-15-47

G54347

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G54347
Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5006 Greenhill Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V

(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto
(If outside city or town limits, write RURAL and give town)

(d) Street No. 5006 Greenhill Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME John A. H. Gerkens

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-16-8371

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife A. Dora Gerkens

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 3rd 1866

8. AGE: Years	Months	Days	If less than one day
80	11	13	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Johann Gerkens
13. Birthplace Germany

MOTHER
14. Maiden Name Johanna Zirkelbach
15. Birthplace Germany

16 (a) Informant Mrs. J. A. H. Gerkens
(b) Address 5006 Greenhill Ave

17 (a) Burial (b) Date thereof 8 20 47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cem
Location Balto Md

18 (a) Funeral director Tarbuton Funeral Home
(b) Address 7401 Belair Rd.

19 (a) 8 17 1947 Huntington W. Williams M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16th 1947, at 1.25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 2 1947, to Aug 16 1947, and that I last saw h alive on Aug 15 1947.

Immediate cause of death

Bronchopneumonia
Myocarditis

	Duration
Due to	10 yr.
Due to	3 yr.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: No

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State).

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Steven Tarbuton M. D.

Address 7530 Belair Rd Date signed Aug 16, 1947

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and correct age is especially important.

G54348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G54348 Registered No.

83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4800 Harford Rd.
(c) Hospital or institution:
Snyder Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mths.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Overlea
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6900 Beech Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma J. McAtee ~~McAtee~~ McATEE

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Walter McAtee
6 (c) If alive, give ~~McATEE~~

7. Birth date of deceased (mo., day, yr.) 2/4/66

8. AGE: Years	Months	Days	If less than one day
81	6	12	..... hr. ..... min.

9. Birthplace Pa (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Arnold Kuhlman
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Schrock
15. Birthplace Germany

16 (a) Informant Mrs. Thomas F. Sullivan
(b) Address 6900 Beech Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 1947 (month) (day) (year)
(c) Cemetery or crematory Kingwood Cem.
Location Kingwood Pa.

18 (a) Funeral director Lansdowne Funeral Home
(b) Address 7401 Belair Rd

19 (a) ..... (Date received by registrar) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16th 1947, at 1 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/15 1947, to 8/14 1947, and that I last saw her alive on 8/14 1947.

Immediate cause of death	Duration
cerebral hemorrhage and thrombosis	4 wks.
Due to	
Due to	
Other Conditions Gen. Arteriosclerosis (Include pregnancy within 3 months of death)	years

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Earl Sullivan M. D.
Address 1250 E North Ave Date signed 8/16/47

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and correct age is especially important.

VS 150

G54349 BALTIMORE CITY HEALTH DEPARTMENT G54349

CERTIFICATE OF DEATH 126 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 32

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3717 3rd ST Baltimore
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary Chronister

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Lloyd E Chronister
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) July 29-1896

8. AGE: Years	Months	Days	If less than one day
50		17	hr. min.

9. Birthplace Landaster Pennsylvania (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business —

FATHER
12. Name William Vincent O'Connor
13. Birthplace Lancaster

MOTHER
14. Maiden Name Mary [illegible] O'Connor
15. Birthplace [illegible] Lancaster

16 (a) Informant Lloyd E Chronister
(b) Address 3717 3rd St Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 19-47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem
Location Gov. Ritchie Highway

18 (a) Funeral director Milton [illegible]
(b) Address 3914 Hanover Street

19 (a) Aug 19 1947 (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 16 Aug 1947 at 3:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 14 Aug 1947 to 16 Aug 1947 and that I last saw h[illegible] alive on 16 Aug 1947

Immediate cause of death	Duration
Pulmonary and Fat Embolism	
Due to Acute Pancreatitis	
Due to Gallstones & Obstruction	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 12 Aug 15 1947
Major findings of operation: Chronic Cholecystitis & Cholelithiasis & Pancreatitis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place) J.M. RAMONDO
(e) Means of injury

23. Signature [signature] M. D.
Address Franklin Square Date signed

PLEASE WRITE PLAINLY. Correct age is especially important. Physicians: please

G54350

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G54350 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland St
(c) Hospital or institution:
Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 15 N. Chester St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Maria Goden Goden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	White	married

6 (b) Name of husband or wife Bernard Goden
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) July 5 1888

8. AGE: Years	Months	Days	If less than one day
59	1	11	hr. min.

9. Birthplace Letova Russia (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business Farming

FATHER
12. Name Not Known
13. Birthplace Russia.

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-17-47 (month) (day) (year)
(c) Cemetery or crematory Pikesville
Location Old Rd & Hamilton Ave

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Baltimore St

19 (a) (Date filed by registrar) (b) Registrar Huntington Williams M.D.

AUG 17 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 1947, at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1947 to Aug 16 1947, and that I last saw h alive on Aug 16 1947.

Immediate cause of death	Duration
Coronary thrombosis	2 days
Due to Hypertensive Cardio vascular disease	4 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph B Goss M.D.
Address 2 E Eutaw Place Date signed Aug 17 1947

PLEASE WRITE WITH INK. Physicians: please be sure that correct age is especially important.

G54351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G54351 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County V
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1535 S. Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma A. Valentine

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: James A. Valentine
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 1-1871
8. AGE: Years 76 | Months 1 | Days 15 | If less than one day hr. min.
9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John W. Conner
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Earl O. Valentine
(b) Address 1535 S. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 18-1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Flynn & Flemings
(b) Address 1426 Light St.

19 (a) Filed AUG 17 1947 (Date received by Registrar) Wellington Williams M.D. Registrar

PLEASE WRITE ... correct age is especially important. Physicians: please write ...

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16 1947, at 3.15 A.M
21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 14 1947 to Aug 16 1947 and that I last saw her alive on Aug. 15 1947
Immediate cause of death Cerebral Hemorrhage — Duration 3 days.
Due to Hypertensive Cardio Vascular disease — years.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Charles Cornwell M.D. M. D.
Address 910 W. Lombard St Date signed 16 Aug. 47

X

G54352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 134a

G54352 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St
(c) Hospital or institution: Bon Secours Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town Baltimore, #30
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1286 Riverside Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maurice - Hampton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Mrs Geraldine Hampton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26. 1900

8. AGE: Years 46 | Months 10 | Days 19 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Rigger

11. Industry or business Shipyard

FATHER 12. Name Maurice Hampton

13. Birthplace

MOTHER 14. Maiden Name Mary White

15. Birthplace Baltimore Md.

16 (a) Informant Mrs Geraldine E. Hampton

(b) Address 1286 Riverside Ave.

17 (a) Burial (b) Date thereof 8-18-1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore Md.

18 (a) Funeral director Plumpe & Fleyenz

(b) Address 1426 Light St.

19 (a) 1947 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 1947 at 11:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-10 1947 to 8-15 1947, and that I last saw h.. alive on 8-15 1947.

Immediate cause of death: Cardio-Resp. Failure — Duration

Due to: Pneumonia Lobar - Left

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation 8-14-47

Major findings of operation: Kidney Calculi

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at , M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature George W Fisher M.D.
Address Bon Secours Hosp Date signed 8-15-47

Direct age is especially important. Physicians: please

G54353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1170

G54353 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 400 N. CAROLINE ST
(c) Hospital or institution: ST JOSEPH'S HOSP
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 WK
(e) Length of stay in Baltimore (yrs., mos., or days) 81

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 811 N. PATTERSON PK. AVE (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME MRS. MARY MILLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	WIDOWED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB 2, 1866

8. AGE: Years	Months	Days	If less than one day
81	6	13	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation AT HOME
11. Industry or business

FATHER
12. Name CARL WEAVER
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant MRS. JOS. FINN
(b) Address 811 Patterson Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 19 47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Holy Redeemer
Location Belair Road

18 (a) Funeral director Thos. J. Kenny Inc
(b) Address 1600 HOLLINS ST

19 (a) (Registered by registrar) (b) Registrar

AUG 17 1947
VS 150 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG 15 1947 at 12 Mid. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/14 1947 to 8/15 1947 and that I last saw h[illegible] alive on 8/15 1947

Immediate cause of death: CARDIO-RESPIRATORY FAILURE — Duration
Due to PERITONITIS, LOCALIZED
Due to PERFORATED PEPTIC ULCER
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 8/15/47
Major findings of operation: PERFORATED PEPTIC ULCER
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry F. Porter M.D.
Address St. Jos Hosp Date signed 8/16/47

X

~~correct age is especially important. Physicians: please write~~

54354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1579

G54354 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Worcester
(c) City or town Snow Hill
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Esther P. Wright

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Female | 5 Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age 14 years

7. Birth date of deceased (mo., day, yr.) 8-12-47

8. AGE: Years — | Months — | Days — | If less than one day: 48 hr. — min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Halbart Wright
13. Birthplace Md.

MOTHER 14. Maiden Name Margaret Wilson
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 19 1947 (month) (day) (year)
(c) Cemetery or crematory Snow Hill
Location Snow Hill Md

18 (a) Funeral director Adams & Lynnis
(b) Address Snow Hill

19 AUG 18 1947 (Date rec'd reg'd) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-17-1947, at 5:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-14-1947 to 8-17-1947
and that I last saw her alive on 8-17-1947

Immediate cause of death	Duration
Atelectasis and Pneumonia	Life
Due to Atresia of esophagus and tracheoesophageal fistula	
Due to and intestinal obstruction -	Life
Other Conditions Pernicious Anemia	3 days

(Include pregnancy within 3 months of death)
Date of operation 8-14-47
Major findings of operation: Atresia of esophagus and tracheoesophageal fistula and
of autopsy: intestinal obstruction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robt Bruce M.D.
Address Johns Hopkins Hosp Date signed 8-19-47

PLEASE WRITE correct age is especially important. Physicians: please

54355 CALLIE

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G54355 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 671 W. Mulberry
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Callie M. Fairfax

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Terry Fairfax
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/1901

8. AGE: Years	Months	Days	If less than one day
46	4		hr. min.

9. Birthplace Dickerson County, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Major Graham
13. Birthplace Western Maryland

MOTHER
14. Maiden Name Florence Jefferson
15. Birthplace Hebbeville Maryland

16 (a) Informant Terry Fairfax
(b) Address 671 W. Mulberry St.

17 (a) (Burial, cremation, or removal) (b) Date thereof Aug 19 47
(month) (day) (year)
(c) Cemetery or crematory Dickerson County Cem.
Location Balto.

18 (a) Funeral director Walter B. Scriggs
(b) Address 139 W. Hamburg Street

19 AUG 18 1947 Huntington Williams, MD

PLEASE WRITE PLAINLY; correct age is especially important. Physicians: please write the causes of death clearly and fully.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/16 1947, at 8:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/14 1947 to 8/16 1947, and that I last saw h e alive on 8/16 1947

Immediate cause of death Coronary Occlusion — Duration

Due to Generalized Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Generalized Arteriosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Porter Grant
Address 15[illegible] Division St Date signed 8/17/47
M. D.

X

54356

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓47c

G54356
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3211 Chesterfield Ave.
(c) Hospital or institution:
home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 58 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3211 ChesterFiELD Ave
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME BERNARD FRANK STANKA

3 (b) If veteran, name war	3 (c) Social Security Account No.
NONE	705 09 2680

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	White	MARRIED

6 (b) Name of husband or wife MARION
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) August 28, 1888

8. AGE: Years	Months	Days	If less than one day
58	11	19	— hr. — min.

9. Birthplace DANZIG, Poland
(Town, county, and state)
10. Usual Occupation CAR INSPECTOR
11. Industry or business B&O RAILROAD

FATHER
12. Name August STANKA
13. Birthplace DANZIG

MOTHER
14. Maiden Name Augusta Koehnke Koenig
15. Birthplace DANZIG

16 (a) Informant MRS. MARION STANKA
(b) Address 3211 CHESTERFIELD AVE

17 (a) BURIAL (b) Date thereof AUG. 20-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Maryland Memorial Park Cem.
Location PARKVILLE MD

18 (a) Funeral director Bernard C. Hartig
(b) Address 121 E West St
Huntington Williams, Md.

AUG 18 1947
(Date received by registrar) Registrar

PLEASE WRITE PLAINLY. Physicians: please write correct age is especially important.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 1947, at 6.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 30 1947 to August 17 1947, and that I last saw him alive on August 16 1947.

Immediate cause of death	Duration
CANCER OF BRONCHUS	6 months
Right Upper Lobe	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Melvin M. Borden M. D.
Address 2030 W. Fayette St Date signed 8/17/47

X

G54357 Lushbaugh

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

122B

Registered No. G54357

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N Carey St
(c) Hospital or institution: Good Samaritan Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 409 E Biddle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel Emiley Lushbaugh

3 (b) If veteran, name war: N
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Charles A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 20, 1902

8. AGE: Years 45 | Months 6 | Days 26 | If less than one day hr. min.

9. Birthplace Emerald N Car (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Johnson Roach
13. Birthplace N Ca

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/47 (month) (day) (year)
(c) Cemetery or crematory National
Location Baltimore Md

18 (a) Funeral director Milligan & Son Inc
(b) Address 1217 E Baltimore St

19 AUG 18 1947 (Date rec'd by registrar) Huntington Milligan, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 14 1947 to Aug. 15 1947 and that I last saw h Ed alive on Aug 15 1947.

Immediate cause of death: Uremia — Duration 3 days
Due to Intestinal Obstruction — 2 days
Due to Post operative
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles Tommaso M. D.
Address 910 W Lombard St Date signed Aug. 14-47.

PLEASE WRITE correct age is especially important. Physicians: please write

VS 150

4358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C54358

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N Carey St
(c) Hospital or institution: Good Samaritan Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 333 N Gay St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrence Burkhardt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: about 82 | Months | Days | If less than one day: hr. min.

9. Birthplace: Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name: Lendrew Burkhardt
13. Birthplace: Wahnyer

MOTHER 14. Maiden Name: Franes Muller
15. Birthplace: Wahnyer

16 (a) Informant: Mrs Eva Kohler
(b) Address: 929 E Eutaw St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/18/47 (month) (day) (year)
(c) Cemetery or crematory: Schwarz MD
Location: Baltimore Md

18 (a) Funeral director: Tilton & Son
(b) Address: 1210 E Oaul St

19 (a) Aug 18 1947 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 14 Aug. 1947, to 19, and that I last saw h[illegible] alive on Aug. 14 1947.

Immediate cause of death	Duration
Myocarditis	
Due to Ch. Myocarditis	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Timmerman M. D.
Address 910 W. Lombard St. Date signed Aug. 16 1947.

PLEASE WRITE ... correct age is especially important. Physicians: please ...

To Miscellaneous X

54359 DC# 56188

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 157a

Registered No. C54359

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 414 E Chase St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George H Loane Jr.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12, 1946

8. AGE: Years	Months	Days	If less than one day
	10	4	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name George Henry Loane Jr.
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Emma Hamburg
15. Birthplace Balto Md

16 (a) Informant Geo Loane Jr
(b) Address 414 E Chase St

17 (a) Funeral (b) Date thereof 8/19/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md
18 (a) Funeral director William J Kelly Inc
(b) Address 1217 E Fayette St
19 (a) AUG 18 1947 (b) Registered for Williams, M.D.
(Date rec'd by registrar) Registrar

correct age is especially important. Physi...

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16 1947, at 3:00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy Eu Chaps thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Hydrocephalus, chronic

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J Kelly M.D.
Medical Examiner.
Date signed Aug 16, 1947

54360

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √52 B

Registered No. G54360

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. ~~1340~~ 1420 Eflwood Ave. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No) If yes, name country

3 (a) FULL NAME Garfield Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mrs Annie Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 6, 1881

8. AGE: Years	Months	Days	If less than one day
65	11	10	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Bricklayer
11. Industry or business

FATHER
12. Name John Thomas
13. Birthplace Wales, British Isles

MOTHER
14. Maiden Name Elizabeth Pollack
15. Birthplace British Isles

16 (a) Informant Annie Thomas
(b) Address 740 S Ellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore Md

18 (a) Funeral director Wilson Co Inc
(b) Address 1217 E Pratt St

19 AUG 18 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

PLEASE WRITE PLAINLY. Physicians: please write the causes of death in such terms as will convey the correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16 1947, at 8:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 11 1947, to Aug 16 1947, and that I last saw h.i.m. alive on Aug 16 1947.

Immediate cause of death	Duration
Uremia	
Due to Epidermoid carcinoma of the bladder	
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation Aug 8, 1947
Major findings of operation: Bladder wall covered with neoplasm
of autopsy: Cancer of bladder

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul G Hurd, M.D.
Address Maryland Gen. Hosp. Date signed Aug 16, 47

M. D.

VS 198

54361

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G54361

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street Address
(c) Hospital or institution South Balto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give county)
(d) Street No. 1563 Abbotston St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Enoch Wills

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Ida Rebecca

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 18 1889

8. AGE: Years	Months	Days	If less than one day
57	7	28	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business P.O. Postal Service

FATHER
12. Name Enoch Wills
13. Birthplace England

MOTHER
14. Maiden Name Elizabeth Lentz
15. Birthplace Baltimore Md

16 (a) Informant Mrs Robert Dover
(b) Address 7814 Oak Ave

17 (a) Burial (b) Date thereof 8/20/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Wilson & Son
(b) Address 1317 E Cold St

19 (a) AUG 18 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

correct age is especially important

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16 1947, at 8:50 P M

21. I certify that I took charge of the remains described above, held an Aug Ed Insp thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J Helfrick M.D.
Medical Examiner.
Date signed Aug 16, 1947

VS 151

54362 Schneyder

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓61

Registered No. G54362

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
M.e.s.y
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 c

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6021 Old Harford Road
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country.....

3 (a) **FULL NAME** Charles Schneyder

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NO

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S.

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1870

8. AGE: Years	Months	Days	If less than one day
76	10		hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Henry Schneyder
13. Birthplace Germany

MOTHER
14. Maiden Name Martha Crause
15. Birthplace Germany

16 (a) Informant Miss Julia Schneyder
(b) Address 6022 Old Harford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/18/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 (a) AUG 18 1947 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15 1947, at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 9 1947 to Aug 15 1947 and that I last saw h.i.m. alive on Aug 15 1947

Immediate cause of death Cachexia
due to.....

Due to Carcinoma Gall Bladder Diabetes Mellitus

Due to.....

Other Conditions Gangrene of left foot & leg & secondary infection

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature W. T. Schneyder M. D.
Address Mercy Date signed 8-13-47

Schnitzker X

PLEASE WRITE PLAINLY, with ink. Physicians: please write the correct age is especially important. Give the causes of death clearly.

54363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G54363 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1114 N. Stricker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) U.S.
If yes, name country

3 (a) FULL NAME Joseph CHAGGETT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Louise Bernelda

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 3, 1879

8. AGE: Years 67 | Months 10 | Days 14 | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Line Foreman

11. Industry or business Florida Power & Light

FATHER 12. Name Luther Blaggett

13. Birthplace Md

MOTHER 14. Maiden Name Becraft

15. Birthplace Md

16 (a) Informant Mrs. Herbert R. Blaggett

(b) Address 7726 N.W. 32 nd Ave. Miami Fla

17 (a) Removal (b) Date thereof 8-18-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location Miami, Florida

18 (a) Funeral director Wm. J. Tichner & Sons

(b) Address North & Penna. Aves

AUG 18 1947 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

correct age is especially important

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/17/47 19 at 8:55 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following.

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R Weis M.D.
Medical Examiner.

Date signed 8/17/47

G54364

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

G54364 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2736 North Howard
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2736 N. Howard (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HENRY J. DUDA

3 (b) If veteran, name war: None

3 (c) Social Security Account No. ?

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Evangeline H. Duda

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1904

8. AGE: Years 43 | Months 1 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Druggist

11. Industry or business

FATHER
12. Name Jerome Duda
13. Birthplace Germany

MOTHER
14. Maiden Name Pauline Dyran
15. Birthplace Germany

16 (a) Informant Mrs. Evangeline H. Duda
(b) Address 2736 N. Howard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/18/47 (month) (day) (year)
(c) Cemetery Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address Northern Pa. Aves. Balto. 17, Md.

19 (a) AUG 18 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

correct age is especially important. Physicians

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/15/47 19 at 11 A. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Sears M.D. Medical Examiner.
Date signed 8/15/47

G54365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No. G54365

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4935 Denmore Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4935 Denmore Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELSIE KRAUSE

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Louis E. Krause
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1, 1888

8. AGE: Years	Months	Days	If less than one day
59	6	14	hr. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual Occupation Home
11. Industry or business

FATHER
12. Name Andrew Schaeffer
13. Birthplace Md.

MOTHER
14. Maiden Name Mary C. Evans
15. Birthplace Md.

16 (a) Informant Mr. Louis E. Krause
(b) Address 4935 Denmore Ave.

17 (a) Burial (b) Date thereof 8/19/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~Crematory~~ Balto. Nat'l Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICHNER & SONS INC.
(b) Address NORTH & PA. AVES. Balto. 17, Md.

AUG 18 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

PLEASE WRITE PLAINLY. Fill in all blanks by typewriter or with pen and ink. Do not use pencil. Be sure to give the correct age in each case. Physicians: please write the cause of death clearly and correctly. The items on this certificate are especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 15, 1947 19 , at 12 Noon M

21. I certify that death occurred on the date above stated; that I attended deceased from July 9th 1947 to Aug 15 1947 and that I last saw h[illegible] alive on Aug 15 1947

Immediate cause of death
Mitral Insufficiency — Duration 7/9/47
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature John D. Bubert M. D.
Address 1803 Eutaw Pl. Date signed 8/16/47

G54366

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No. G54366

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1943 Ridgehill Ave (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Sarah Brownlee SARAH S. BROWNLEE

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: ~~Widowed~~ Divorced

6 (b) Name of husband or wife: Thomas M. Brownlee

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 4-13-73

8. AGE: Years 74 | Months 4 | Days 2 | If less than one day ..... hr. ..... min.

9. Birthplace: Md (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: George Zionek
13. Birthplace: Md

MOTHER
14. Maiden Name: Henrietta Ingham
15. Birthplace: Md.

16 (a) Informant: Records Mrs. S. Shepler
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 8/19/47 (month) (day) (year)
(c) Cemetery ~~Crematory~~ Mt. Carmel, Balto. Co.
Location Balto. County, Md.

18 (a) Funeral director: WM. J. TICKNER & SON INC.
(b) Address: North & Pa. Aves. Balto. 17, Md.

AUG 18 1947 (Date rec'd by Registrar)
(b) Thurlington Williams M.D. Registrar

V S 150

PLEASE WRITE PLAINLY. Physicians: please write correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15 1947 at 10 20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10 1947 to Aug 15 1947, and that I last saw her alive on Aug 15 19 47.

Immediate cause of death	Duration
Rupture Bladder	7 days
Generalized Peritonitis	5 days
Due to Carcinoma of Bladder	1 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 8-11-47.

Major findings of operation: Generalized Carcinomatosis.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature W. C. Shepler Jr. M. D.

Address Johns Hopkins Hosp. **Date signed** 8-16-47

G54367

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

G54367 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2513 Edmondson Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2513 Edmondson Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME John E. Edenfield JOHN EZEKIEL EDENFIELD

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Erna Hanson Edenfield
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 1, 1889

8. AGE: Years	Months	Days	If less than one day
58	4	16	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Trainman
11. Industry or business B. & O. R. R.

FATHER
12. Name James H. Edenfield
13. Birthplace Md.

MOTHER
14. Maiden Name Ida S. Kirwan
15. Birthplace Md.

16 (a) Informant Mrs. John E. Edenfield
(b) Address 2513 Edmondson Ave.

17 (a) Burial (b) Date thereof 8/20/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Loudon Park Cem.
Location Balto. Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md

19 (a) AUG 18 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 August 1947 at 12 A.M.

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy find that said deceased came to h[illegible] death on the day stated above.

Immediate cause of death Hypertensive C.V. Disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify kind of place) While at work?
(e) Means of injury

23. Signature [signature] M.D.
Medical Examiner
Date signed 15 Aug. 47

correct age is especially important. Physicians, please write plainly.

VS 6

54368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 121

Registered No. G54368

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
St. Agnes Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1929 W. Mulberry St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME John L. McGinnis JOHN LESLIE McGINNIS

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Miriam L. McGinnis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27, 1903

8. AGE: Years	Months	Days	If less than one day
44	—	20	hr. min.

9. Birthplace Dover, N. J.
(Town, county, and state)
10. Usual Occupation Gas Maker
11. Industry or business Gas & Elec. Co.

FATHER
12. Name James E. McGinnis
13. Birthplace Castleton, Vt.

MOTHER
14. Maiden Name Agnes E. Wall
15. Birthplace Dayton, Ohio

16 (a) Informant Mrs. J. L. McGinnis
(b) Address 1929 W. Mulberry St.

17 (a) Burial (b) Date thereof 8/20/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Mt. Olivet Cem.
Location Baltimore Md.

18 (a) Funeral director Wm. J. TICHNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

19 (a) AUG 18 1947 (b) Carlton Williams, Balto, Md.
(Date rec'd by registrar)

VS 150

PLEASE WRITE PLAINLY with pencil or pen and ink. Physicians: please write correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-17-47 19.., at M

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 17 1947 to Aug 17 1947, and that I last saw him alive on Aug 17.

Immediate cause of death	Duration
Acute peritonitis	
Due to Perforated appendix	
Due to	
Other Conditions Coronary sclerosis	

(Include pregnancy within 3 months of death)
Date of operation Aug 23/47
Major findings of operation: Perforated appendix
of autopsy: Was offered.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Albert Harrison M. D.
Address St. Agnes Hosp Date signed August 27/1947

54369 BCH F 39807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

14a

G54369 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3734 Beech Ave
(c) Hospital or institution:

13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3734 Beech Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME WILL GOOCH TRAVELSTEAD JR.

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 27 Nov 1947

8. AGE: Years 5 | Months 8 | Days 19 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md (town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Will Gooch Travelstead
13. Birthplace Tenn.

MOTHER
14. Maiden Name Elizabeth Vance
15. Birthplace Ala.

16 (a) Informant Mother Mr. W. G. Travelstead Jr.
(b) Address 3734 Beech Ave.

17 (a) Removal (Burial, cremation, or removal) **(b) Date thereof** 8/18/47 (month) (day) (year)
(c) Cemetery or crematory Franklin, Ky.
Location Franklin, Ky.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Fa. Aves., Balto. 17, Md.

19 (a) AUG 18 1947 (Date rec'd by registrar) **(b)** Huntington Williams, M.D.

VS 150

PLEASE WRITE PLAINLY. Physicians: please write correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH 16 August 1947, at 11:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1946 to Aug 1947, and that I last saw h alive on July 1 1947.

Immediate cause of death Myeloid Leukemia — **Duration**

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Campbell Goodwin M. D.
Address 16 E Biddle St **Date signed** 16 Aug 47

X

G54370 — ISAIAH TURNER —

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G54370 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 944 Leadenhall
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 944 Leadenhall St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Turner, Isaiah

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Col	M.

6 (b) Name of husband or wife Rosie
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/4/87

8. AGE: Years	Months	Days	If less than one day
72 73	6	10	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Shipping Clerk
11. Industry or business Clothing

FATHER
12. Name David L. Turner
13. Birthplace Md

MOTHER
14. Maiden Name —
15. Birthplace

16 (a) Informant Eva Howe
(b) Address 944 Leadenhall St.

17 (a) Burial (b) Date thereof 8/18/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Ct
Location Balto. Co., Md.

18 (a) Funeral director David L. Brown & Son
(b) Address 1048 N. Montgomery St.

19 (a) (b) Huntington Williams, M.D.
(Signature of local registrar) (Address)

AUG 18 1947

VS 150

PLEASE WRITE PLAINLY. Physicians: please write the cause of death in terms which describe the disease, injury, or complication directly causing death. Do not use terms of mode of dying, such as heart failure, asphyxia, anemia, or uremia. Please report only one cause in each item. Do not enter diseases merely contributory to death. Please fill in items 20 to 23 and sign certificate. Be sure that your handwriting is legible and that you state your address correctly. Please answer all questions. Write out the full name of the street or rural route number. Please state age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/14/47 19 , at 1 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-2-47 19 47 to 8/14/47 19 47.
and that I last saw h alive on 8/14/47 19

Immediate cause of death Pneumonia
Due to Carcinoma of Descending Colon
Due to
Other Conditions Secondary Anemia

Duration
Cont.

(Include pregnancy within 3 months of death)
Date of operation 3/11/47 - 3/17/47
Major findings of operation: Carcinoma of Descending Colon
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury Henry C. Welcome
23. Signature [redacted] M. D.
Address Provident Hospital (Place, Baltimore)

8/18/47

54371 Shives

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. G54371

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A. A.
(c) City or town Ferndale (If outside city or town limits, write RURAL and give town)
(d) Street No. 200 Broadview Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME E. Willard Shives
3 (b) If veteran, name war ✓
3 (c) Social Security Account No. 215-18-9420
4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Edith C. Shives
6 (c) If alive, give age 60 years
7. Birth date of deceased (mo., day, yr.) FEB-7 1876
8. AGE: Years 71 | Months 5 | Days 10 | If less than one day ____ hr. ____ min.
9. Birthplace WEST VA. (Town, county and state)
10. Usual Occupation Gasoline Sta. Attendant
11. Industry or business Ship Service - Annapolis
FATHER 12. Name Thomas Mc. Kelvey Shives
13. Birthplace Pa.
MOTHER 14. Maiden Name Mary E. Nicholson
15. Birthplace Unknown
16 (a) Informant Edith C. Shives
(b) Address 200 Broadview Blvd. - Ferndale
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 20. 1947 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Memorial
Location A. A. Co. Md.
18 (a) Funeral director Mr. & Mrs. John H. Teufel & Son
(b) Address 5311 Edmondson Ave
19 AUG 18 1947 Huntington Williams M.D. (Date received by registrar) (Registrar)

PLEASE WRITE PLAINLY with indelible pencil. Physicians: please write the causes of death in such a way that the correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 Aug 1947, at 1:05 AM
21. I certify that death occurred on the date above stated, that I attended deceased from 15 Aug 1947 to 17 Aug 1947, and that I last saw him alive on 17 Aug 1947.

Immediate cause of death: Pulmonary Edema — Duration
Due to: Congestive Heart Failure
Due to: Arteriosclerotic Hypertension & Heart Disease
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Joseph L. Matchar
Address 1531 Balt Co. Date signed 17 Aug 47

VS 150

54372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 186a

Registered No. G54372

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2706 Reisterstown Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Goldberg

3 (b) If veteran, name war: 1st World War
3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Fanny

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1899

8. AGE: Years: 48 | Months: 8 | Days: | If less than one day: hr. min.

9. Birthplace: Balto Md (Town, county and state)

10. Usual Occupation: Auto Machanic

11. Industry or business

FATHER — 12. Name: Hyman
13. Birthplace: Russia

MOTHER — 14. Maiden Name: Lena
15. Birthplace: Russia

16 (a) Informant: Fanny Goldberg
(b) Address: 2706 Reisterstown Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8-19-47 (month) (day) (year)
(c) Cemetery or crematory: United Hebrew
Location: Washington Boulevard

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 200 Eutaw Place

19 (a) AUG 18 1947 (Date received by Registrar) Huntington Williams, M.D. Registrar

correct age is especially important

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 16 1947, at 7:50 P.M.

21. I certify that I took charge of the remains described above, held an Aug Ed Incp thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Hes death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Shock, surgical

Due to: Fracture of Left Leg, right foot, Severe left rib and internal injuries.

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: Aug 15th at 1947 at 6:30 A.M. 15/5
(b) Where did injury occur? 2706 Reisterstown Road
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury: Was skylarking on roof and fell off

23. Signature: William J. Helfrich M.D. Medical Examiner.
Date signed: Aug 17, 1947

VS 191

54373 ROY

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 131a

G54373 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hosp. 19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 518 N. Calhoun St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abraham S Ray

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	married

6 (b) Name of husband or wife Lena Ray
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec ? 1869

8. AGE: Years	Months	Days	If less than one day
77	8		hr. min.

9. Birthplace King Queen Co, Va.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Joshua Ray
13. Birthplace King Queen Co Va

MOTHER
14. Maiden Name Minerva ?
15. Birthplace Va

16 (a) Informant Lena Ray
(b) Address 518 N. Calhoun St

17 (a) Burial (b) Date thereof Aug 18-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park
Location Arbutus Md

18 (a) Funeral director Robert E Williams
(b) Address 515 McElderry St

19 AUG 18 1947 Huntington Hill Cemetery, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/14/1947, at 2 00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/7/1947 to 8/14/1947 and that I last saw h alive on 8/14/1947

Immediate cause of death Coronary Sclerotic Heart Dis.
Chronic nephritis

Duration
over

Due to

Due to

Other Conditions Dehydration
Abdominal
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. A. M. Harris / Dr. A. M. Johnson
Address Superintendent Hosp. Date signed 8/16/47 M. D.

VS 150

X

54374

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G54374 Registered No.

49a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga + Calvert Sts
(c) Hospital or institution: Mercy Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3001 Greenmount St.
(If rural give location)
(e) Citizen of foreign country? ~~Former~~ No)
If yes, name country

3 (a) **FULL NAME** Miss Marie Chittick

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 11, 1890

8. AGE: Years	Months	Days	If less than one day
56	8	5	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation School teacher
11. Industry or business

FATHER
12. Name William J. Chittick
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Catherine Scoales
15. Birthplace Pennsylvania

16 (a) Informant Miss Marie Chittick
(b) Address 3001 Greenmount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 20/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Harry H. Woltze
Address 1524 Edmondson Ave

19 (a) (b) Huntington Williams M.D.

AUG 18 1947
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 1947, at 11 35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19..., to 19..., and that I last saw her alive on Aug 16 1947.

Immediate cause of death Cardiac failure
with pulmonary edema.

Duration

Due to Generalized Carcinomatosis

Due to Carcinoma, papillary of pelvis of kidney.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 3/17/47

Major findings of operation: Carcinoma of pelvis of kidney and adj. organs.

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry V. Chase M. D.
Address Mercy Hospital Date signed 8/17/47

PLEASE WRITE PLAINLY, WITH INK. Underline the causes of death clearly and legibly. Give correct age is especially important. Physicians: please write the

VS 150

X

4375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓937

G54375 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey St.
(c) Hospital or institution: Good Samaritan Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 309 N. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H. Cole

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1876

8. AGE: Years	Months	Days	If less than one day
71	3 2	16	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name James R. Cole
13. Birthplace Md

MOTHER
14. Maiden Name Melissa Patterson
15. Birthplace Va.

16 (a) Informant Mrs. Carrie A. Brennan
(b) Address 107 Annapolis Blvd Ferndale

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 18 47 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location 3801 Frederick Rd

18 (a) Funeral director Harry H. Nitzke
(b) Address 496 Edmondson Ave

19 (a) AUG 18 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16 47, 19, at 12.25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 12 1947, to Aug. 16 1947, and that I last saw him alive on Aug. 16 1947.

Immediate cause of death Acute heart failure — Duration Immediate

Due to Arteriosclerotic heart disease — Duration years

Due to —

Other Conditions Senility.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles Tommarello M.D. M. D.
Address 910 W. Lombard St. Date signed 18 Aug. X 1947.

PLEASE WRITE PLAINLY. Physicians: please write the cause of death clearly and correct age is especially important.

VS 150

G54376 BCH B-85806

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH ✓ 160a

G54376 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town ~~Baltimore~~ Owings Mills,
(If outside city or town limits, write RURAL and give town)
(d) Street No.....
(If rural give location)
(e) Citizen of foreign country? No (~~Yes~~ or No)
If yes, name country.....

3 (a) FULL NAME Baby Boy Bange

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-10-47

8. AGE: Years	Months	Days	If less than one day
		7	14 hr. 5-6 min.

9. Birthplace Bon Secours Hosp. (Town, county, and state)
10. Usual Occupation -
11. Industry or business -

FATHER
12. Name Harry N. Bange
13. Birthplace Owings Mills

MOTHER
14. Maiden Name Dorothy N. Keeney
15. Birthplace Frankstown, Md.

16 (a) Informant Harry N. Bange
(b) Address Owings Mills, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 18, 1947 (month) (day) (year)
(c) Cemetery or crematory Saint Thomas
Location Garrison Forest

18 (a) Funeral director Wm. Berryman & Sons
(b) Address Reisterstown, Md

19 (a) AUG 18 1947 (b) Huntington Williams, M.D. Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

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MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17 1947, at 5-6 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10 1947, to Aug 17 1947, and that I last saw h~~im~~ alive on Aug 17 1947.

Immediate cause of death	Duration
Cerebral accident*	
Due to Cran. birth injury	
Due to	
Other Conditions Prematurity	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature William F. Carr M. D.
Address Bon Secours Hosp. Date signed 8-12-47

G54377 Leeke

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1947

G54377 Registered No.

PLEASE WRITE PLAINLY, with unfading ink. Fill all blanks. Give the causes of death clearly and legibly. Use only standard abbreviations. Do not use ditto marks. Be sure the correct age is especially important. Physicians: please write the cause of death in the space provided.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1714 Eutaw Place
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1714 Eutaw Pl (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Amelia M Leeke

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Frank
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13 1871

8. AGE: Years 76 | Months 3 | Days 3 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Andrew Heim
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Germany

16 (a) Informant: E J Farry
(b) Address 1819 N Eutaw St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-19-47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Govt Co Yard

18 (a) Funeral director Geo A Jahn
(b) Address Guilford + Fayette

AUG 18 1947 (Date filed) (by) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16 1947 at 10 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1947 to Aug 16 1947 and that I last saw her alive on Aug 16 1947.

	Duration
Immediate cause of death: Congestive Heart Failure	one week
Due to: Arteriosclerosis	10 years
Due to: Heart Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Conrad Wallenstein M.D.
Address 1 E W 36 St Date signed 8/16/47

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54378

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 195E

G54378
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1310 N. Chester st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Szymon Sime Lustica

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-6400

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Married

6 (b) Name of husband or wife Antonette

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
63.			hr. min.

9. Birthplace Jugoslavia
(Town, county, and state)

10. Usual Occupation Longshoreman

11. Industry or business

FATHER
12. Name Antoni Lustica
13. Birthplace Jugoslavia

MOTHER
14. Maiden Name Anna
15. Birthplace Jugoslavia

16 (a) Informant Antonette Lustica
(b) Address 1310 N. Chester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 19-47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto. Co.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern ave

19 AUG 18 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

correct age is especially important. Physicians, please

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-16- 1947, at 2:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Loss death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemorrhage and Shock

Due to Crushed rt. thigh with severed Femoral artery

Other Conditions + Compound fracture Rt. femur.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8/16/47 at 2 a. M.
(b) Where did injury occur? Aboard "Mamanteick" Pier #1 Canton, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Struck by steam.

23. Signature Earl K. Moyer M.D.
Medical Examiner.
Date signed 8-16-47

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54379

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G54379 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Sq Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) (Dec'd)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2547 W North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie Lehman Shipley
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/7/1890

8. AGE: Years	Months	Days	If less than one day
57	1	9	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Lawyer
11. Industry or business Building

FATHER
12. Name David E Shipley
13. Birthplace Maryland

MOTHER
14. Maiden Name Minnie Sandfort
15. Birthplace Maryland

16 (a) Informant Gertrude Shipley
(b) Address 136 Newburg st

17 (a) Burial (b) Date thereof 8/19/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto City

18 (a) Funeral director Geo. L. MacNabb
(b) Address Catonsville Md

(a) Date received AUG 18 1947 (b) Registrar Covington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/16 1947 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/16 1947 to 8/16 1947 and that I last saw h[illegible] alive on 8/16/47 1947

Immediate cause of death: Cerebral Apoplexy — Duration: 5 minutes
Due to: Hypertensive Cardio Vascular disease
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. Lloyd R. Ravenscroft M. D.
Address Franklin Square Hospital Date signed 8/18/47

PLEASE WRITE PLAINLY, with pen and ink. Physicians: please write the causes of death clearly and report correct age is especially important.

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G54380 BC# B-25348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 186a

Registered No. G54380

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Provident Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 55 min
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2540 Madison Ave
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Barbara Lee Carter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 5/30/45

8. AGE: Years 2 | Months 2 | Days 17 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation.....
11. Industry or business.....

FATHER
12. Name Phillip Carter
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Annett Hutton
15. Birthplace Balto., Md.

16 (a) Informant Phillip Carter
(b) Address 2540 Mad. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-19-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto., Md.

18 (a) Funeral director Charles L. Law
(b) Address 802 Madison Ave

19 (a) [illegible] (Address rec'd) (Date rec'd) 8/18/47 Contingent Williams M.D.

VS 151

correct age is especially important. Information must be given for all persons, whether white or colored.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16, 1947, at 6 55 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intracranial hemorrhage

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8/16/47 Appx. 5 45 P.M. 17 3
(b) Where did injury occur? 2540 Madison Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fell from high chair

23. Signature [illegible] M.D.
Medical Examiner

Date signed 8/18/47

54381

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G54381

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Ill. (b) County.....
(c) City or town Chicago
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4706 Champaign Ave
(If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Nellie Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charley

6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) 2-10-82

8. AGE: Years 65 | Months 6 | Days 6 | If less than one day ..... hr. ..... min.

9. Birthplace Indiana
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Amos Lyons
13. Birthplace Indiana

MOTHER
14. Maiden Name Lucretia Adams
15. Birthplace Indiana

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-21-47 (month) (day) (year)
(c) Cemetery or crematory Burr Oak Cem
Location Chicago, Ill.

18 (a) Funeral director CHAS. R. LAW
(b) Address 807 MADISON AVE. Huntington Williams, Md.

19 (a) AUG 18 1947 (Date rec'd by registrar) (b) ..... Registrar

V S 150

PLEASE WRITE PLAINLY. Physicians: please write the causes of death in such terms that a correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16. 1947. at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 2 1947 to Aug 16 1947 and that I last saw h alive on Aug 16 1947.

Immediate cause of death	Duration
Operation for Peritonitis	2 days
Due to	
Due to	
Other Conditions None to Physicians Pneumonia (Include pregnancy within 3 months of death)	1 yr

Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....
23. Signature.....
Address Johns Hopkins Hosp. Date signed ..... M. D.

X

4382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1935

Registered No. G54382

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3714 Milford ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3714 Milford Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louisa Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John Frederick Davis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13-1882

8. AGE: Years	Months	Days	If less than one day
65	4.	3	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation House Duties
11. Industry or business

FATHER
12. Name James Isaac
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary E. Stevens
15. Birthplace Rock Hall Md.

16 (a) Informant Mrs. Russell B. Joynes
(b) Address 3601 Howard Park Ave

17 (a) Burial (b) Date thereof Aug. 19-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Baltimore Md.

18 (a) Funeral director Mamie Cook Syfer
(b) Address 1600 W. North Ave

19 AUG 18 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16 1947 at 6-45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 1947 to Aug 16 1947, and that I last saw h[illegible] alive on Aug 16 1947.

Immediate cause of death	Duration
Coronary Thrombosis	15 minutes
Due to Myocardial disease	6 mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E W Koons M. D.
Address 1202 St Paul St Date signed 8/18/47

PLEASE WRITE PLAINLY. Physicians: please write the cause of death clearly. Be sure to give correct age as especially important.

V S 150

54383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G54383

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Eaton Avenue
(c) Hospital or institution: Jenkins Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 N. Chilton Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa Koerner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24 1876

8. AGE: Years 71 | Months 0 | Days 23 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name Christian Koerner
13. Birthplace Germany

MOTHER
14. Maiden Name Anna M. Endres
15. Birthplace Germany

16 (a) Informant Mrs. Joseph Griffin
(b) Address 3205 Bayonne Ave

17 (a) Burial (b) Date thereof 8/19/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Red
Location Md

18 (a) Funeral director L. J. Ruck
(b) Address 5305 Harford Rd

19 (Date received by registrar) AUG 18 1947 Huntington Williams, M.D. Registrar

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PLEASE WRITE PLAINLY. Use ink. Do not abbreviate the causes of death clearly and accurately; correct age is especially important. Physicians: please write the

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 14 1947 10:10 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/23/37 to 5/16/47 and that I last saw h[illegible] alive on 8/12 1947.

Immediate cause of death: Coronary failure - Hypertension Cardio Vascular Disease

Due to: Cerebral Vascular accident

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.

Address 8 Hagner Date signed 8/14/47

Dr. Hichew
54384

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G54384

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6401 Harford Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6401 Harford Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert J. Vollmer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Gertrude B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 3, 1870

8. AGE: Years	Months	Days	If less than one day
76	8	11	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Grocery, Owner
11. Industry or business

FATHER
12. Name Fred J. Vollmer
13. Birthplace Germany

MOTHER
14. Maiden Name Louise ?
15. Birthplace Germany

16 (a) Informant Mrs. Louise Gettier
(b) Address 6401 Harford Road, 14

17 (a) Burial (b) Date thereof 8/18/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Baltimore, Maryland

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) AUG 18 1947 (Date rec'd by Registrar) Huntington Hillcrest, M.D. Registrar

V S 150

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly, without abbreviations. Be sure to fill in all items. Omit no information which you may have. Please see that the correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 14th, 1947, at 1.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 1947, to Aug 14 1947, and that I last saw h[illegible] alive on Aug 14 1947.

Immediate cause of death	Duration
Acute pulmonary oedema	1 day
Due to Chronic myocardial disease	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Lee Hichew
Address 4116 Northern Pkwy Date signed 8/12/47

X

54385 JL- 112979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V13B

G54385 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1218 E. Monument st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Garnetta Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1904

8. AGE: Years	Months	Days	If less than one day
43	3	15	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William McGrooder
13. Birthplace Md.

MOTHER
14. Maiden Name Mamie McGrooder
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 19 47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A.A. County Md

18 (a) Funeral director Wm Robt Ellis Jr
(b) Address 1129 N. Caroline St

19 (a) AUG 18 1947 (Date Rec'd by Registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16 1947, at 7.55A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 13 1947, to Aug. 16 1947, and that I last saw her alive on Aug. 16 1947.

Immediate cause of death	Duration
Respiratory failure	3 da
Due to Tuberculosis of lungs for advanced	3½ yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: see above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph J. Beaver Jr M. D.
Address Balto City Hosp Date signed 8-17-47

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

VS 150

G54386
431897

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
1223

G54386
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1144 E. Lombard, St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl Singleton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	Col	Married

6 (b) Name of husband or wife Emanuel Singleton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1920

8. AGE: Years	Months	Days	If less than one day
27			hr. min.

9. Birthplace N.C.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Cowan
13. Birthplace N. C.

MOTHER
14. Maiden Name Chaney Colbert
15. Birthplace N.C.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Aug 20, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Shaddy Grove
Location Salisbury, N.C.

18 (a) Funeral director Chronath Wilson
(b) Address 1000 Blantley Ave

19 (a) (b)
(Date rec'd) (Registrar)

AUG 18 1947

S 150

PLEASE WRITE PLAINLY, with ink or indelible pencil, and write the cause of death carefully and legibly. Physicians: please write correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug-16 - 1947 at 2.00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1947 to Aug 16 1947 and that I last saw h[illegible]ive on Aug-16 1947

Immediate cause of death Peritonitis — Duration 12 hr
Due to Intestinal Obstruction — Duration
Due to and Perforation — Duration 6 days
Other Conditions Gonnorheal Salpingitis
(Include pregnancy within 3 months of death)
Date of operation 8/16/47
Major findings of operation: Peritonitis, intestinal obstruction, perforation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Thomas N. H. Johns M.D.
Address Johns Hopkins Hosp Date signed 8/16/47

X

G54387

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G54387
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Dr. Drepsho
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County N.Y.
(b) City or town Baltimore New York
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2350 Preston Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VISVILDES (ZISVKLDIS) Schnore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex m

5. Color or race w

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-26-1895

8. AGE: Years 52 | Months 6 | Days 22 | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Floor Layer

11. Industry or business

FATHER
12. Name Peter Schnore
13. Birthplace Latvia

MOTHER
14. Maiden Name Alida Zickmanis
15. Birthplace Latvia

16 (a) Informant Walter B Cooke
(b) Address New York N Y

17 (a) Cremation (b) Date thereof 8/18/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Hope
Location New York N Y

18 (a) Funeral director Wilson Cook Inc
(b) Address 1314 St Paul St
(Signature) Washington Williams (b)
(Address) Baltimore, Md.

AUG 18 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/17/47 19 , at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 8/17/47

correct age is especially important. Physician, please

G54388

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G54388 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use the causes of death clearly and legibly. Correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1335 Ward St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1335 Ward St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Perkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	married

6 (b) Name of husband or wife Mary Perkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4 1877

8. AGE: Years	Months	Days	If less than one day
70	5	14	hr. min.

9. Birthplace David County N. C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mildred Austin
(b) Address 1335 Ward St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-18-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 W. Schroeder St

19 (a) Date AUG 18 1947 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/15/47 19 , at 1130 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/26 1947 to 8/15 1947.
and that I last saw h[illegible] alive on 8/14 1947.

Immediate cause of death	Duration
Arterioscleroti[illegible]	
Cardio-vascular disease	7
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. D. Lupo
Address 11 E. Chase St Date signed 8/16/47

Lupo X

G54389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G54389 Registered No.

166

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Harman
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Mundell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C.	M.

6 (b) Name of husband or wife Gertrude Mundell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1897

8. AGE: Years	Months	Days	If less than one day
49	10	22	hr. min.

9. Birthplace Harmans A. A. Co. Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Aaron Mundell
13. Birthplace A. A. County, Md.

MOTHER
14. Maiden Name Libby Hawkins
15. Birthplace A. A. Co. Md.

16 (a) Informant Mrs. Gertrude Mundell
(b) Address Harmans, Md.

17 (a) Burial (b) Date thereof 8-19-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Marks
Location A. A. County, Md.

18 (a) Funeral director Mrs. K. R. Williams
(b) Address 322 N. Schroeder St

19 (a) 1947 Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 15, 1947, at 6 28 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Gun-shot wound of abdomen and colon.
Peritonitis
Paralytic ileus of intestine.
~~Other Conditions~~
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-9-47 at 11 P.M.
(b) Where did injury occur? Harmans, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No.
(d) Means of injury Firearms - Shotgun
23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 8/16/47

X

Correct age is especially important. Physicians: please write plainly.

G54390 Gambrell

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

G54390 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4663 Pimlico Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4663 Pimlico Rd (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Harold F. Gambrell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Katherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31, 1902

8. AGE: Years 45 | Months 2 | Days 15 | If less than one day hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation Lawyer Salesman

11. Industry or business

FATHER 12. Name William Gambrell
13. Birthplace S. C.

MOTHER 14. Maiden Name Daisy Mae Halliday
15. Birthplace S. C.

16 (a) Informant Katherine Gambrell
(b) Address 4663 Pimlico Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-18-47 (month) (day) (year)
(c) Cemetery or crematory Woodbridge
Location Woodbridge

18 (a) Funeral director George A Farley
(b) Address Fulton Ave & Fayette St

19 (a) (Date rec'd by registrar) Huntington Williams Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15 1947 at 8 20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1947 to Aug 15 1947 and that I last saw h[illegible] alive on Aug 15 1947.

Immediate cause of death: (a) Intestinal obstruction — Duration 20½ hr.
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. L. DeBaufre M. D.
Address 4723 Park Heights Ave Date signed 8/18/47

VS-150 AUG 19 1947 John R. Davis MD /per E. A. Merrill MD X

G54391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G54391 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3010 Guilford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 33

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3010 Guilford Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emily Jackson Blunt

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Attwood Blunt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 8-1865

8. AGE: Years	Months	Days	If less than one day
81	10	8	hr. min.

9. Birthplace Northampton Co., Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name John A. Doughty
13. Birthplace Virginia

MOTHER
14. Maiden Name Emily Wilkins
15. Birthplace Virginia

16 (a) Informant A. Fitzallen Blunt
(b) Address 3010 Guilford Ave

17 (a) Cremation (b) Date thereof Aug 18-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Putnam & Hoke
(b) Address 32 W. Lafayette

AUG 18 1947
(Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16th 1947, at 9 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1947 to August 1947, and that I last saw h er alive on June 1947.

Immediate cause of death	Duration
Pulmonary Hemorrhage	
Due to Pulmonary Tuberculosis	6 months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Chas. P. Hautzenroder Jr., M.D.
Address 1207 Eutaw Place Date signed 18 Aug 47

Received Aug 18 1947 Registrar, Washington Hill, Md.

PLEASE WRITE PLAINLY, with pencil. Use ink. Do not abbreviate. Give the causes of death clearly and legibly. Correct age is especially important. Physicians: please write the cause of death in such a way that it may be understood by the lay public.

54392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

Registered No. C54392

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3809 Colborne Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3809 Colborne Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas B. Dailey

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Angela E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7th 1898

8. AGE: Years 49 | Months 5 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Shop Helper

11. Industry or business Package goods

FATHER 12. Name John F. Dailey

13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Margaret M. W. Lee

15. Birthplace Baltimore Md

16 (a) Informant Mrs Angelia E Dailey

(b) Address 3809 Colborne Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 20, 47 (month) (day) (year)

(c) Cemetery or crematory Loudenslager

Location 4300 Old Frederick Road

18 (a) Funeral director John J Conway & Son

(b) Address 901-07 Hollins St.

19 (a) Date received by Local Registrar AUG 18 1947 (b) Huntington Hollins M.D. Registrar

Please answer all questions. Be sure that the correct age is especially important. Physicians: please write plainly.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16 1947, at 4:45 M

21. I certify that I took charge of the remains described above, held an Aug 18 Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature William J Helfrich M.D. Medical Examiner.

Date signed Aug 16, 1947

X

393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 654393

PLEASE WRITE PLAINLY, WITH INK. Use no abbreviations. Do not write the causes of death clearly and legibly. correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 866 Carroll St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 866 Carroll St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George J. O'Neal, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Anna M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 14, 1888

8. AGE: Years 58 | Months 8 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Self

FATHER
12. Name Thomas F. O'Neal
13. Birthplace Md

MOTHER
14. Maiden Name Watertown
15 Birthplace Md

16 (a) Informant Mrs Anna M. O'Neal
(b) Address 866 Carroll St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd

18 (a) Funeral director John F. Conway & Co
(b) Address 29-33 S. Eutaw St

19 (a) AUG 18 1947 (Date filed by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16 1947, at 2:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/10 1948 to 8-16 1948 and that I last saw h— alive on 8-16 1948

Immediate cause of death	Duration
Acute Cardiac Failure	1 hr
Due to Cerebrovascular Hemorrhage	6 mos
Due to Stroke	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph L. Lattanzi
Address 1719 Washington Blvd Date signed 8/16/47

V S 150

G54394

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G54394 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 540 W. Lafayette Ave,.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 540 W. Lafayette Ave,. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME PAULINE EDNA BURKE - NEE (Pauline Rhodes)

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-14-9065

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife William Burke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1, 1905

8. AGE: Years 42 | Months 6 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name James Riley
13. Birthplace Baltimore, Maryland.

MOTHER 14. Maiden Name Helen Rhodes
15. Birthplace Baltimore, Maryland.

16 (a) Informant Mrs. Helen Porter
(b) Address 540 W. Lafayette Ave,.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8.20.47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location U.S. Rt. 301, Prince Geo.

18 (a) Funeral director William A. Jackson
(b) Address 916 Pennsylvania Ave,

19 (a) AUG 18 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

PLEASE WRITE PLAINLY, with pencil or pen. In reporting causes of death write the causes of death clearly and legibly. Use only standard abbreviations. Do not use ditto marks. Be sure that the answers are complete and correct age is especially important. Physicians: please write your name and address.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1947, at 8: P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-15 1947 to 8-17 1947, and that I last saw her alive on 8-17 1947.

Immediate cause of death	Duration
Cardiac failure	
Coronary thrombosis	
Due to Hypertensive Card-Vas Dis	7
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R B Livingston M. D.
Address 501 Cherry Hill Rd. Date signed 8-17-47

X

54395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. C54395

PLEASE WRITE PLAINLY, with ink. Use typewriter if possible. Do not abbreviate. Be sure to write the causes of death clearly and legibly. Correct age is especially important. Physicians: please write your name and address in item 21.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2402 W. Lafayette ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2402 W. Lafayette ave.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE J. PAVLEROS

3 (b) If veteran, name war ---
3 (c) Social Security Account No. --

4. Sex: Male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife --
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec. 19, 1914
8. AGE: Years 32 | Months 7 | Days 26 | If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Confectionery Business
11. Industry or business

FATHER
12. Name James Pavleros
13. Birthplace Greece

MOTHER
14. Maiden Name Stavroula Spanakos
15. Birthplace Greece

16 (a) Informant James Pavleros
(b) Address 2402 W. Lafayette ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/47 (month) (day) (year)
(c) Cemetery or crematory Greek Orthodox
Location Evangelismos

18 (a) Funeral director Jos. L. Agnew Funeral Home Inc
(b) Address 718 W. Mt. Royal Ave.

19 (a) (Date received by registrar) AUG 18 1947 (b) Huntington Williams, M.D. Registrar

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 15 19 47 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 29 1947 to Aug 15 1947 and that I last saw him alive on Aug 15 1947.

Immediate cause of death: Cerebral Hemorrhage — Duration 1 hour
Due to arterial Hypertension — 2 yrs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. M. Johnson
Address 403 Medart Pl Date signed 8/16/47

54396

FL - 111328

BALTIMORE CITY HEALTH DEPARTMENT 8/a

CERTIFICATE OF DEATH

Registered No. G54396

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 115 S. Castle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Hand

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1908

8. AGE: Years	Months	Days	If less than one day
38	11	2	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles E. Hand
13. Birthplace Md.

MOTHER
14. Maiden Name Sophie Hand
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/20/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Lilly & Zeller Sons
(b) Address 403 S. Dolfield Ave

19 AUG 18 1947 (Date rec'd by Registrar) Huntington Williams M. D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16 19 47, at 1.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 11, 1947 to Aug. 16 19 47, and that I last saw h[im] alive on Aug. 16 19 47

Immediate cause of death	Duration
Respiratory Depression	1 hr
Due to Pyogenic Staphylococcic	1 da
Due to Secondary infection of Tuberculous Osteomyelitis 7th	2 mos

Other Conditions 8th Cervical Vertebra
Tuberculosis of lung, ulnar amputation
(Include pregnancy within 3 months of death)
Date of operation 6-20 & 6-27-47
Major findings of operation: Tuberculous osteomyelitis and granulation tissue
of autopsy: see above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph J. Bowen Jr M. D.
Address Balt City Hosp Date signed 8-17-47

54397

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH (1937)

Registered No. G54397

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1420 Caroline St.
(c) Hospital or institution: St Joseph's Hospital Balto. Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Balto.
(c) City or town Baltimore (Zone 24) (If outside city or town limits, write RURAL and give town)
(d) Street No. 3 N Ellwood Ave (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Walter H. Wilkinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Alice Warner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2 - 85

8. AGE: Years 62 | Months 2 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James W.
13. Birthplace Md.

MOTHER
14. Maiden Name Sally Trimble
15. Birthplace Md

16 (a) Informant Alice Wilkinson
(b) Address 3 N. Ellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Dorsey Ave Ext.

18 (a) Funeral director Sulley & Zeller Co.
(b) Address 403 S. Arlington Ave

19 AUG 18 1947 (Date rec'd by registrar) Arlington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 1947, at 4.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1947, to Aug 16 1947 and that I last saw h[im] alive on Aug 16 19 47.

Immediate cause of death	Duration
Cardio-respiratory failure.	
Due to Cerebral Vascular accident	
Due to (Contusion Hemorrhage) Acute Hypertensive Cardio-Vascular disease	
Other Conditions Cardiac decompensation	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Harry P. Porter
Address St. Joseph Hosp Date signed 8/16/47 M.D.

PLEASE WRITE PLAINLY, with ... write the causes of death clearly and correct age is especially important. Physicians: please write ...

VS 150

G54398
G54397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G54398

PLEASE WRITE PLAINLY, with ink. Use no abbreviations. Be sure to write the causes of death clearly and legibly. Be sure correct age is especially important. Physicians: please write your

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1435 N. Patterson Pk. Ave.
(c) Hospital or institution:
4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
4 City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1435 N. Patterson Pk. Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Augusta Sloake

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Charles Sloake

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15 - 1864

8. AGE: Years 83 | Months 6 | Days 2 | If less than one day hr. min.

9. Birthplace Hanover, Germany
(Town, county, and State)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace "

MOTHER 14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs Pauline Sternhart
(b) Address 1435 N. Patterson Pk. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-19-47 (month) (day) (year)

(c) Cemetery or crematory Parkwood Cem.
Location John C. Weller Inc.

18 (a) Funeral director 2435 E. Oliver St.
(b) Address

19 (a) AUG 18 1947 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-19 1947 at 12:55 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1944 to 8/17 1947, and that I last saw h alive on 8/16 1947.

Immediate cause of death: Arteriosclerotic heart disease — Duration: ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Max Baum

Address 1501 N. Milton Ave. Date signed 8/18/47

X

G54399

G54399

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G54399 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 613 Brant St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 613 Brant St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leroy Hughes

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14, 1940

8. AGE: Years 7 | Months 4 | Days 3 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Authur D. Madden
13. Birthplace —

MOTHER 14. Maiden Name Edythe M. Hughes
15. Birthplace Balto. Md.

16 (a) Informant Edythe M. Hughes
(b) Address 613 Brant st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Irvine Grumbs Co. Md.

18 (a) Funeral director William J. Shetman Jr.
(b) Address 1701 McCulloh St.

19 (a) AUG 18 1947 (Date registered) Huntington Williams, M.D. (Signature of city registrar) Registrar

VS 3

PLEASE WRITE PLAINLY. correct age is especially important. Physicians: please write

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-17-47 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-12-47 19 , to 8-17-47 19 , and that I last saw h[illegible] alive on 8-15-47 19 .

Immediate cause of death BRONCHO PNEMONIA

Duration 2 days

Due to STARVATION

Due to

Other Conditions PARTIAL PARALYSIS
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Marie Allen M.D.

Address 239 N. Caroll St. Date signed 8-18-47

X

G54400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 53 ✓

G54400
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey Sts
(c) Hospital or institution: Bond Sanitarium Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. Back River Neck Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Nolt NOOFT
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Constantine Noffsinger 6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) July 15 1879

8. AGE: Years 68 | Months 1 | Days 26 | If less than one day hr. min.

9. Birthplace Poland (town, county, and state)

10. Usual Occupation farmer

11. Industry or business

FATHER — 12. Name Noofft
13. Birthplace Polish

MOTHER — 14. Maiden Name Unk
15. Birthplace Poland

16 (a) Informant Mrs Constantine Noffsinger
(b) Address Back River Neck Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 19 PM (month) (day) (year)
(c) Cemetery or crematory Locust Point
Location Pennsylvania Ave & Fort

18 (a) Funeral director John B Connelly
(b) Address 418 Eastern Ave

19 (a) AUG 18 1947 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16 1947, at 4:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 13 1947, to Aug. 16 1947; and that I last saw him alive on Aug. 15 1947.

Immediate cause of death: Toxic Miocarditis — Duration: 48 hrs.
Due to: Carcinomatosis — 6 Years
Due to: Carcinoma of face — Unknown
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles Ernest Am. J. M. D.
Address 910 W. Lombard St Date signed 16 Aug 47

X

54401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G54401

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1624 N Port
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1624 N Port
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Caroline Schmidt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widowed

6 (b) Name of husband or wife Charles W Schmidt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 14 1872

8. AGE: Years	Months	Days	If less than one day
74	11	6 3	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Lawrence Friskey
13. Birthplace Md

MOTHER
14. Maiden Name Klein
15. Birthplace Md

16 (a) Informant Charles W. Schmidt Jr
(b) Address 1300 N Kenwood Ave

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Aug 20 1947 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Anne Arundel Co Md

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St Washington Boulevard

19 (c) AUG 18 1947 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 August 1947, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 28 July 1947 to 17 Aug 1947 and that I last saw h[illegible] alive on 12 Aug 1947

Immediate cause of death	Duration
Left Ventricular Failure	2 Months
Due to Arteriosclerosis	
Due to [illegible]	
Other Conditions Pernicious Anemia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1513 N. Washington Ave Date signed 12 Aug 47

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Exact age is especially important.

V S 150

97

654402

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

Register 654402

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2243 Lake Ave.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2243 Lake Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Alfred Sause

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10. 1912

8. AGE: Years	Months	Days	If less than one day
35	0	6	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name J. Conrad Sause
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth Greif
15. Birthplace Baltimore, Md.

16 (a) Informant J. Conrad Sause
(b) Address 2243 Lake Ave-13.

17 (a) Burial (b) Date thereof Aug. 18, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Colgate, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.,

19 (a) AUG 19 1947 Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

V S 150

PLEASE WRITE PLAINLY. Use ink. Do not use pencil. Do not write the causes of death directly and vaguely. Be sure to correct age is especially important. Physicians: please write legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16, 1947 19 , at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 11 1947 to Aug 16 1947 and that I last saw h alive on July 15 1947

Immediate cause of death Uremia - chr. Nephritis
Condition - renal disease
Due to my o cardial failure
Mitral insufficiency
Due to

Duration
Aug 11/47
Aug 11/47

Other Conditions Marked life recurrent
mitral birth (tuberculosis)
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury

23. Signature Louis F Ullrich M. D.
Address 722 N Kenwood Ave Date signed Aug 19 47

54403

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G54403 Registered No.

PLEASE WRITE PLAINLY, with ink. Use no abbreviations. Be sure write the causes of death clearly and correct age is especially important. Physicians: please write

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert St.

(c) Hospital or institution: Union Memorial Hospital.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 47 days

(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 712 E. 41st Street. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Clarence L. Essex

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Ruth Essex

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) April 15 1890

8. AGE: Years 57 | Months 56 | Days 4 | If less than one day ... hr. ... min. 2

9. Birthplace Maryland, Baltimore (Town, county, and state)

10. Usual Occupation Maintenance Man

11. Industry or business Distillery

FATHER 12. Name William Essex

13. Birthplace Maryland

MOTHER 14. Maiden Name Barbara Reichardt.

15. Birthplace Maryland.

16 (a) Informant Ruth Essex

(b) Address 712 E. 41st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 20 47 (month) (day) (year)

(c) Cemetery or crematory Lorraine

Location 5608 Dogwood Rd.

18 (a) Funeral director John R. Moran

(b) Address 3066 E. Balt. St.

19 (a) AUG 18 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17th 1947, at 1:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947, to Aug 17 1947 and that I last saw h... alive on ... 19...

Immediate cause of death	Duration
Bronchopneumonia	3 da.
Uremia	
Due to Hypertensive Cardiovascular Disease	2 mo
Due to Chronic glomerulonephritis	2 yr.
Other Conditions Diabetes Mellitus	9 yr.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ... at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Thomas R. Freeman M.D.

Address Union Memorial Hosp. Date signed Aug 17, 1947

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54404

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

100B

G54404 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Fill the causes of death clearly and legibly. correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3120 Sequoia Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3120 Sequoia Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margarethe Roes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife William Roes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 27, 1868

8. AGE: Years 79 | Months 4 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John B. Kalb
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta
15. Birthplace Germany

16 (a) Informant Mr. Carl Walter Roes
(b) Address 119 Clarenden Ave., Pikesville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 19, 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director [illegible]
(b) Address [illegible] Liberty Heights Ave. Huntington Mortuary, Inc.

19 (a) AUG 18 1947 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 1947, at 3.08A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1946 to Aug. 16 1947, and that I last saw her alive on Aug 15 1947.

Immediate cause of death	Duration
Pulmonary Infarct	4 days
Phlebitis	1 week
Due to Carcinoma Obstetrica	4 mo.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. A. Estes M. D.
Address 3911 Maine Ave. Date signed 8-16-47

VS 150

654405

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 654405

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner & Dukeland and
(c) Hospital or institution:
West Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 340 S. Payson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George H. Linthicum

3 (b) If veteran, name war —

3 (c) Social Security Account No. 705-05-2146

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Carrie I. Schmidt
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) June 19, 1881

8. AGE: Years	Months	Days	If less than one day
66	6	26	....hr. ....min.

9. Birthplace Baltimore, Md.
(Town, county and state)
10. Usual Occupation Boiler Maker Helper
11. Industry or business B. T. O. R.R.

FATHER
12. Name Shreeby Linthicum
13. Birthplace Howard Co. Md.

MOTHER
14. Maiden Name Emma F. Fowler
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Carrie Linthicum
(b) Address 340 S. Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 19 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Fred. A. Cole
(b) Address 1934 W. Lombard St

19 (a) AUG 18 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 15 1947, at 10.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1946 to Aug 15 1947 and that I last saw him alive on Aug 15, 1947.

Immediate cause of death Bronchial Pneumonia — Duration 4 days
Due to
Due to
Other Conditions Acute Myocardial Degeneration
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alfred Cole M. D.
Address 1934 W. Fulton Ave. Date signed 8-18-47

PLEASE WRITE PLAINLY. Write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

V S 150

107

G54406

BALTIMORE CITY HEALTH DEPARTMENT ✓ G54406 Registered No.

CERTIFICATE OF DEATH 83a

PLEASE WRITE PLAINLY, with ink. Physicians: please write the causes of death clearly and legibly. Use no abbreviations. Accuracy in every detail is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1529 N. Wolfe Street
(c) Hospital or institution: home
(d) Length of stay in hospital or inst. (yrs., mos., or days) -
(e) Length of stay in Baltimore (yrs., mos., or days) -

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1529 N. Wolfe Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick George Batzer

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no-

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Regina
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): August 5, 1861

8. AGE: Years: 86 | Months: 0 | Days: 13 11 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Road Foreman- Retired
11. Industry or business: C. And P Telephone Co.

FATHER
12. Name: George Batzer
13. Birthplace: Bavaria, Germany

MOTHER
14. Maiden Name: Dorothea Christ
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Mrs. Mary McGee
(b) Address: 1910 E. 29th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 19 (month) (day) (year)
(c) Cemetery or crematory: Cemetery
Location: Most Holy Redeemer Cemetery

18 (a) Funeral director: Wm. Cook, Inc.
(b) Address: 1217 St. Paul Street

(a) AUG 18 1947 (b) (Date rec'd by) Carrington Williams, M. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 1947, at 11:5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 24 1947, to Aug. 16, 1947, and that I last saw him alive on Aug. 16, 1947.

Immediate cause of death	Duration
Crebral hemorrhage	3 days
Due to Arteriosclerosis & Cerebral sclerosis	1 yr.
Due to	
Other Conditions Partial paralysis	4 m.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward G. Sugrue M. D.
Address 1613 E. North Ave. Date signed 8-18-47

G54407

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45F

G54407 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 704 E 37th St Balto 18 Md.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., ~~mos. or days~~) 50

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 704 E 37th St. Balto, Md.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Valentine Vincent Redmond.

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 216-09-8392

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Irene A.
6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) Sept 12 (1905)

8. AGE: Years (41) | Months 11 | Days 16 | If less than one day: hr. min.

9. Birthplace St. Marys County MD
(Town) (county, and state)

10. Usual Occupation Steam fitter
11. Industry or business "

FATHER
12. Name Phillip Henry Redmond
13. Birthplace St. Marys County MD

MOTHER
14. Maiden Name Mary Magill
15. Birthplace St. Marys County, Md

16 (a) Informant Valentine E Redmond.
(b) Address 704 E 37th St Balto Md.

17 (a) Burial (b) Date thereof 8/21/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) Huntington Williams, M.D. (b)
(Date received by registrar) Registrar

AUG 18 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 1947, at 6 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1947, to Aug 17 1947, and that I last saw him alive on Aug 17 1947.

Immediate cause of death: Cancer of Left tonsil — Duration: 9 Months
Due to
Due to
Other Conditions: Biopsy
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Cancer left tonsil.
of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, or in public place?
(Specify type of place) While at work?
(e) Means of injury

NATHAN WOLF M.D. 4117 BELVIEDERE AVE. BALTIMORE 15, MD.

23. Signature Nathan Wolf
Address 4117 Belvieder Ave Date signed M. D. 17 47

X

4408

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 111c

G54408 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 918 S. Wolfe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Elmer Hayes

3 (b) If veteran, name war

3 (c) Social Security Account No. 411-14-4876

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 27, 1905

8. AGE: Years	Months	Days	If less than one day
92	5 6	10	hr. min.

9. Birthplace Tenn (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Elza H. Hayes
13. Birthplace N. C.

MOTHER
14. Maiden Name Fisher Hatley
15. Birthplace Tenn

16 (a) Informant R. L. Shinault, Johnson City Tenn
(b) Address 903 W. Myrtle St, Johnson City Tenn

17 (a) Removal (b) Date thereof Aug 19/49 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Elizabethon Tenn
Location Walnut Hill, Elizabethon Tenn

18 (a) Funeral director Phillips Stewart Sons
(b) Address 2024 Carlton St.

19 (a) (Undertaker or Local Registrar) Huntington Williams M.D. (Registrar)
(b) AUG 19 1949

VS 191

correct age is especially important. Physicians: please write

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 17, 1949 at 4 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Edema of brain
Edema of lungs
~~Due to~~ History of convulsions

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 8/18/49

409

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G54409

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 N Cold Spring Lane
(c) Hospital or institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Govd Park
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry N Wales

3 (b) If veteran, name war
3 (c) Social Security Account No.

4 Sex: Male | 5 Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lemonde S
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16 1880

8. AGE: Years 67 | Months 3 | Days 2 | If less than one day: hr. min.

9. Birthplace Ga (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

MOTHER / FATHER
12. Name Sam Wales
13. Birthplace Ga
14. Maiden Name Emma Johnson
15. Birthplace Ga

16 (a) Informant Elva Kiernan
(b) Address 1609 N Gay St
17 Burial (Burial, cremation, or removal) (b) Date thereof 8/20/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Md
Location Baltimore Md
18 (a) Funeral director Wilson Cook Inc
(b) Address 2147 Eutaw St
(c) AUG 19 1947 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

PLEASE WRITE PLAINLY, with unfading ink. Do not use pencil. Be sure to write the causes of death clearly and report correct age is especially important. Physicians: please write the causes of death clearly and report correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18 1947, at 8 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from MAY 11 1947 to Aug 18 1947, and that I last saw him alive on 8-15 1947.

	Duration
Immediate cause of death: PNEUMONIA	4 days
Due to: CEREBRAL HEMORRHAGE	2 yrs
Due to: Hypertensive Cardio Vascular Disease	7
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Thomas R. Kiernan M. D.
Address 3803 Edmondson Ave Date signed 8/12/47

54410

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

G54410
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8 Roberts Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ulysses G. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan., 1907

8. AGE: Years	Months	Days	If less than one day
40	8	15	hr. min.

9. Birthplace Howard Co. Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Augustus Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Martha Jones
15. Birthplace Md.

16 (a) Informant Mrs. Clara King
(b) Address 182 Vintera Lane

17 (a) Burial (b) Date thereof 8-22-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Star
Location Baltimore Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Riddle St.

(c) Date received by registrar AUG 19 1947 Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

45

20. DATE OF DEATH Aug. 16 1947, at 10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary arteriosclerosis
Acute edema of lungs

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrell M.D.
Medical Examiner.
Date signed 8/18/47

X

Correct age is especially important. Physicians: please write

G54411

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G54411

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Write the word "None" where it is the correct answer. Do not abbreviate or use ditto marks. Be sure that the cause of death is stated so that it can be understood by a stranger. Do not use symptoms or modes of dying. Write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3005 Brighton Street
(c) Hospital or institution:
16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5-7 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3005 Brighton St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Giuseppi Maniglia

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	

6 (b) Name of husband or wife Domenica
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years	Months	Days	If less than one day
79			hr. min.

9. Birthplace Italy (town, county, and state)
10. Usual Occupation Produce
11. Industry or business

FATHER
12. Name Adgew Maniglia
13. Birthplace Italy

MOTHER
14. Maiden Name Curreri
15. Birthplace Italy

16 (a) Informant Mrs Sarah Serio
(b) Address 3041 Presstman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location Old Frederick Road

18 (a) Funeral director Joseph Turse & Son
(b) Address 2013 Greenmount Ave.

AUG 19 1947 (Date rec'd by Registrar) Huntington Williams M.D.

VB 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-16- 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-13- 1947 to 8-16 1947 and that I last saw h[illegible] alive on 8-16- 1947.

Immediate cause of death	Duration
Cerebral Haemorrhage	12 hrs
Due to Arteriosclerosis	years
Due to Old age	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert C. Blake

Address Med. Arts Bldg. Date signed 8-17-47

412

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30E

Registered No. 54412

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use typewriter if possible. Do not write the causes of death clearly and legibly. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 9-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1621 Eaton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a). FULL NAME Peter Scheidegger

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-1787

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-28-84

8. AGE: Years	Months	Days	If less than one day
62	11	18	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Peter Scheidigger
13. Birthplace Switzerland

MOTHER
14. Maiden Name Justina Ripple
15 Birthplace Germany

16 (a) Informant Recorder
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 20/47 (month) (day) (year)
(c) Cemetery or crematory Trinity
Location Baltimore

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St

19 (a) (Date received by registrar) AUG 19 1947 (b) Registrar Huntington Williams, MD

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16 1947 at 3:35 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 13 1947 to Aug 16 1947 and that I last saw h alive on Aug 16 1947

Immediate cause of death	Duration
Cardiovascular Syphilis	15 yrs +
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Mark F. Hackenga M.D.
M. D.
Address Johns Hopkins Hospital Date signed 17 Aug '47

X

54413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G54413
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use typewriter if possible. Do not write the causes of death clearly and legibly. correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 336 St. Dunstans Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 336 St. Dunstans Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME REV. GEORGE W. HADDAWAY

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Amelia R. Haddaway
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1865

8. AGE: Years	Months	Days	If less than one day
82	2	26	hr. min.

9. Birthplace Tilghmans Is. Md. (Town, county, and state)
10. Usual Occupation Minister
11. Industry or business

FATHER
12. Name John S. E. Haddaway
13. Birthplace Talbot Co. Md.

MOTHER
14. Maiden Name Mary Jane Fox
15. Birthplace Accomac. Co. Va.

16 (a) Informant Mr. K. K. Haddaway
(b) Address 336 St. Dunstans Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk. Cem.
Location Baltimore Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. Md.

AUG 19 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 18, 1947 19..., at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 6 1947, to Aug 18 1947 and that I last saw him alive on Aug 18 1947.

Immediate cause of death	Duration
1 Hypertensive Cardio Vascular-renal disease	many yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: No
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury No

23. Signature H. G. Thomas M.D.
Address 2818 Pa Ave Date signed 8/18/47

414

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a

Registered No. G54414

PLEASE WRITE PLAINLY, WITH UNFADING INK. Do not write the causes of death clearly and legibly. correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 805 S. Eaton St.
(c) Hospital or institution: 26-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 805 S. Eaton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Antoinette A. Minikine

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife George M. Minikine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1899

8. AGE: Years	Months	Days	If less than one day
47	7	19 21	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Manicurist
11. Industry or business

FATHER
12. Name Andrew C. Poetzel
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Anna S. Kappan
15. Birthplace Germany

16 (a) Informant Anna S. Poetzel
(b) Address 805 S. Eaton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/20/47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Road

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

AUG 19 1947 (a) (Date received by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-17-47 19 , at 1020 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-15 1947 to 19 , and that I last saw h alive on 8/17 1947.

Immediate cause of death	Duration
coronary artery sclerosis	hours ?
acute pulmonary edema	
Due to arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Huntington Williams M. D.
Address 2320 Eutaw St Date signed 8/19/47

X

4415

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 96

✓ G54415 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered or "unknown" inserted where it is impossible to obtain correct answer. Give the causes of death clearly and legibly. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6002 Charlesmead Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-12
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6002 Charlesmead Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Philinda Margaret Johnson Murray

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: John F. Murray Jr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3, 1892

8. AGE: Years 55 | Months 3 | Days 10 | If less than one day hr. min.

9. Birthplace Hillsville, N. Y. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles P. Johnson
13. Birthplace Hillsville, N. Y.

MOTHER
14. Maiden Name Emma Elliott Marsh
15. Birthplace Hillsville, N. Y.

16 (a) Informant Dr. John F. Murray
(b) Address 6002 Charlesmead Rd.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 8/20/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave. Balto. Md.

18 (a) Funeral director John O. Mitchell Funeral Home
(b) Address 1900 Eutaw Place

AUG 19 1947 (Date received by Registrar) Huntingtown Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18 1947, at 8 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/16/47 19 to 8/18/47 19, and that I last saw h[illegible] alive on 8/18/47 19

Immediate cause of death: Subarachnoid Hemorrhage — Duration: 10 min

Due to Cerebral aneurysm ? — ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Subarachnoid Hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. W. Lowenwright M.D.
Address 9 E. Chase St. Baltimore Date signed 8/19/47

VS 150

54416

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G54416 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or Institution: Mercy Hosp 5-
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3 N Eden St (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Charles R Rhodes

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July , 1887

8. AGE: Years	Months	Days	If less than one day
60	1		hr. min.

9. Birthplace Amherst County, Va. (Town, county, and state)

10. Usual Occupation carpenter

11. Industry or business

FATHER
12. Name Charles Albert Rhodes
13. Birthplace Amherst County, Va.

MOTHER
14. Maiden Name Julia Casey
15. Birthplace Amherst County, Va.

16 (a) Informant W. C. Whitten
(b) Address Lynchburg, Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn, Md.

18 (a) Funeral director John M Mitchell & Sons, Inc
(b) Address 1900 Eutaw Place

AUG 19 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

20. DATE OF DEATH Aug 13 1947, at 5 CO M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular

Due to disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature W. G. Kelbach M.D. Medical Examiner.
Date signed Aug 13, 1947

PLEASE WRITE PLAINLY. Physicians: please write the causes of death correctly. Exact age is especially important.

VS 151

54417

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. G54417

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey Street
(c) Hospital or institution Good Samaritan Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 606 Pitcher Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Franklin E. Bonds

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Negro	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace Hartford Co., Maryland
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Bernice Davis
(b) Address 606 Pitcher Street

17 (a) Burial (b) Date thereof Aug 19 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore, Md.

18 (a) Funeral director Geo. W. Zelsers
(b) Address 1303 Pennsylvania Ave.

19 AUG 19 1947 (c) Huntington Williams M.D.
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 1947, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1st 1947, to Aug 15 1947, and that I last saw h[illegible] alive on Aug 15 1947.

Immediate cause of death Bronchopneumonia Ca. — Duration years.
Due to Bone Metastasis
Due to
Other Conditions Senility
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles [illegible] M. D.
Address 960 W. [illegible] Date signed Aug. 19 1947.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered or a line drawn through it. Be sure the causes of death clearly and legibly. correct age is especially important. Physicians: please write the

G54418

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓163B

Registered No. G54418

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 11-
(d) Length of stay in hospital or inst. (yrs., mos., or days) d. o. a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1315 N. Calvert st
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Florence Grace Darden (Shively)

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	S

6 (b) Name of husband or wife Roy Shively
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) March 12 1918

8. AGE: Years	Months	Days	If less than one day
29	5	7	X hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Clerk.
11. Industry or business

FATHER
12. Name Hiram L. Darden
13. Birthplace Virginia

MOTHER
14. Maiden Name Addie F. Johnson.
15. Birthplace Virginia

16 (a) Informant Addie F. Darden (Mother)
(b) Address 1432 Holbrook Street

17 (a) Burial (b) Date thereof 8/23/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. North Ave. Balto Md.

18 (a) Funeral director George. J. Ruth Inc
(b) Address 1735 Hanford Ave

19 (Date rec'd by registrar) AUG 19 1947 Huntington Williams, M.D.

20. DATE OF DEATH August 19th 1947, at 24 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Barbiturate Poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Aug. 19th/47 M.
(b) Where did injury occur? 1315 N. Calvert st
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Ingestion of 15 sleeping tablets.

23. Signature [signature] M.D.
Medical Examiner
Date signed 8/19/47

PLEASE WRITE PLAINLY. Use this change of death certificate only to correct age is especially important. Physicians: please write

VS 151

G54419

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G54419

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1600 Lamont Avenue
(c) Hospital or institution:

9-9

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 32 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1600 Lamont Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bastiana Torre

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Augustino Torre
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Jan. 20 1882

8. AGE: Years 65 | Months 6 | Days 27 | If less than one day: ######## hr. ____ min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Salvatora Arcoracci
13. Birthplace Italy

MOTHER
14. Maiden Name Mary ?
15. Birthplace Italy

16 (a) Informant Maria Torre
(b) Address 1600 Lamont Avenue

17 (a) Burial (b) Date thereof 8/20/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location [redacted], Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 AUG 19 1947 Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 17th 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1947 to Aug. 16 1947, and that I last saw her alive on Aug 15 1947.

Immediate cause of death: Bronchopneumonia — Duration 3 days

Due to:

Due to:

Other Conditions: Diabetes Mellitus — ?

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Joseph L. Blum M.D.
Address 1206 E. Preston St. Date signed 8/18/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

VS 150

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G54420

G54420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G54420

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given and causes of death clearly and legibly. Physicians: please write the causes of death so that correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1302 E. Lafayette Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) None 9-9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1302 E. Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Anna Hanretty

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 18, 1875

8. AGE: Years	Months	Days	If less than one day
72	6	29	###### min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Christopher Hanretty
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Agnes McGee
15. Birthplace Ireland

16 (a) Informant James P. Hanretty
(b) Address 1302 E. Lafayette Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Avenue Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) (b) Huntington Williamsport Md
AUG 19 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 17th 1947, at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1946 to Aug 17 1947
and that I last saw h alive on Aug 15 1947

Immediate cause of death Uremia

Due to hypertensive arteriosclerotic

Due to Cardiovascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jack J. Swiger
Address 506 E. Northern Date signed 8/18/47

X

G54421

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 131a

Registered No. G54421

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Road
(c) Hospital or institution:
Snyder Nursing Home 27
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2825 Chesterfield Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret C. McLean (Magdalene McLean)

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: George L. McLean
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) April 18, 1882

8. AGE: Years 65 | Months 3 | Days 29 | If less than one day: ###### hr. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: John Lorek
13. Birthplace: Poland

MOTHER
14. Maiden Name: Mary Nowakowski
15. Birthplace: Poland

16 (a) Informant: Mrs. Monica C. Boerschel (Daughter)
(b) Address: 3402 Dudley Avenue, Balto: Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/47 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Edmondson Ave. Balto: Md.

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 AUG 19 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) (Registrar) Address 112 S St Paul St Date signed 8/18/47

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 17th 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1947 to Aug 17 1947 and that I last saw her alive on 16 1947.

Immediate cause of death	Duration
Cardiac Failure	
Due to Hypertension	
Due to Nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Williams M. D.

PHYSICIAN
Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Be sure to state the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

VS 150

54422

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (1937)

G54422 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be answered or the word "unknown" or the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1823 W. Pratt St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1823 W. Pratt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Estella M. Johnson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Harry J. Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23. 1872

8. AGE: Years 74 | Months 7 | Days 25 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation H.W.

11. Industry or business

FATHER 12. Name Ogle
13. Birthplace England

MOTHER 14. Maiden Name unknown
15. Birthplace U.S.A.

16 (a) Informant Mrs. Harry J. Johnson
(b) Address 1823 W. Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 21/47 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave. + Loyola St.

18 (a) Funeral director Harry H. Kirkpatrick
(b) Address 4101 Edmondson Ave

AUG 19 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/18 1947, at 4:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/17 1947 to 8/18 1947 and that I last saw h e alive on 8/18 1947

Immediate cause of death: Hypertension cardio vascular disease — Duration 6 yr.
Due to
Due to
Other Conditions Cerebral Hemorrhage — 1 day
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Benjamin Miller M. D.
Address 2070 Wilkens Ave Date signed 8/19/47

54423

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. 54423

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered; write the causes of death clearly and legibly. Use no abbreviations or ditto marks. Be sure that the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 110 Elmwood Ave. #10

(c) Hospital or institution: Union Memorial Hospital 27-15

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 d.

(e) Length of stay in Baltimore (yrs., mos., or days) 69 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. city (If outside city or town limits write RURAL and give town)

(d) Street No. 110 Elmwood Ave (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Elizabeth E. Rusk.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/18/1876

8. AGE: Years	Months	Days	If less than one day
70 69	10	0	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name George Glanville Rusk.

13. Birthplace Maryland.

MOTHER

14. Maiden Name Mary Yeisley

15. Birthplace Maryland

16 (a) Informant George Yeisley Rusk

(b) Address 110 Elmwood Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/47 (month) (day) (year)

(c) Cemetery Greenmount

Location Baltimore, Md.

18 (a) Funeral director John M. Mitchell & Sons, Inc.

(b) Address 1900 Eutaw Place

19 AUG 19 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18 1947, at 6 25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/15 1947, to 8/18 1947 and that I last saw her alive on 8/18 1947.

Immediate cause of death	Duration
Heart Failure precipitated by Blood Transfusion necessitated	
Due to by fractured left hip and anemia due to ?	4 days.
Due to Hypertension	- ?
Other Conditions	- ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Hypertensive cardiovascular disease with pulmonary edema

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 27/13

(a) Accident, suicide, or homicide Accident

(b) Date of occurrence 8/14/47 at P M

(c) Where did injury occur? Balto, Md. (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No

(e) Means of injury Fall to floor

23. Signature Howard J. Sanders, M. D.

Address Union Memorial Hosp. Date signed 8/18/47 M. D.

54424

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G54424 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be made in full. Do not abbreviate. Write the causes of death clearly and legibly. Give correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 42 N. Carlins St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-
(e) Length of stay in Baltimore (yrs., mos., or days) 38 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 42 N. Carlins St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Schoen

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Julius Schoen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1872

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Schwebett
13. Birthplace Russia

MOTHER
14. Maiden Name Russie —
15. Birthplace Russia

16 (a) Informant Joseph Schoen
(b) Address 42 N. Carlins St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-19-47 (month) (day) (year)
(c) Cemetery or crematory Rest Dale
Location

18 (a) Funeral director JCR Lewis Inc.
(b) Address 2107-02 Eutaw Place Huntington Williams, Mgr.

19 (a) AUG 19 1947 (Date received by local registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19 1947, at 7 30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1947 to Aug 18 1947 and that I last saw h[illegible] alive on Aug 18 1947

Immediate cause of death	Duration
Coronary Occlusion	
Myocarditis	
Arteriosclerosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
(f) Signature Benjamin Kaplan M. D.
Address 2306 Eutaw Pl Date signed 8-19-47

X

54425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C54425

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. Y. (b) County
(c) City or town New York (If outside city or town limits, write RURAL and give town)
(d) Street No. 215 W. 94th St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mina Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1915

8. AGE: Years	Months	Days	If less than one day
32			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/20/47 (month) (day) (year)
(c) Cemetery or crematory Parsons Cem't.
Location Salisbury, Md.

18 (a) Funeral director Selby & Sexauer
(b) Address

19 (a) AUG 19 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/17 1947, at 9A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Lev death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fractured skull and intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8/17/47 at approximately 12:30 P.M.
(b) Where did injury occur? On lawn in front of 4305 Parkmont Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Blunt force

23. Signature [signature] M.D. Medical Examiner.
Date signed 8/18/47

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Cause antecedent to cause, morbid conditions, if any, giving rise to immediate cause, should be stated. Do not use abbreviations or symbols. Indefinite or unsatisfactory terms, such as "Heart Failure," "Asthenia," "Old Age," "Senility," "Cancer," "Tumor," should not be used alone. Be sure that cause of death is stated in accordance with the above instructions. Be sure that age is entered in every case.

VS 151

54426 LW D.O.A.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V/107

Registered No. G54426

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 18-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 43 S. Arlington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Victor Howard Faulkner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 13. 1944

8. AGE: Years 3 yrs | Months 4 | Days 4 | If less than one day ____ hr. ____ min.

9. Birthplace Wash. D. C.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Benjamin Faulkner
13. Birthplace Portsmouth N. H.

MOTHER
14. Maiden Name Myrtle ~~Faulkner~~ Hayes
15. Birthplace Bowie Md.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Aug. 20 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto Co. Md.

18 (a) Funeral director Mr. Mrs. John H. Teufel - Lou
(b) Address 5311 Edmondson Ave

19 (a) AUG 19 1947 Thonnington Williamson, M.D.
(Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 17- 19 47 at 2:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 17 19 47 to Aug. 17 19 47, and that I last saw him alive on Aug. 17 19 47

Immediate cause of death DoA
Bronchopneumonia

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Bronchopneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. A. Becker
Address Balto City Hosp Date signed 8/18/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given. Write the causes of death clearly and legibly. Be sure that correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C54427

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered C54427

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given. Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 24 N Carey St
(c) Hospital or institution: Good Samaritan Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-2
(e) Length of stay in Baltimore, (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1316 N Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles J Hull

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 17 1880
8. AGE: Years 67 | Months 4 | Days 27 | If less than one day hr. min.
9. Birthplace Brooklyn NY (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Dept of Welfare
(b) Address Baltimore Md
17 (a) Burial (b) Date thereof 8-20-47 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md
18 (a) Funeral director Wilson & Son Inc
(b) Address 1217 St Paul St
19 (a) Registered (b) Registered Huntington Williams, M.D.

AUG 19 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 14 1947, to 19; and that I last saw h[illegible] alive on Aug. 14 1947.

Immediate cause of death: Acute Cardiac failure — Duration: 1 day.
Due to: Coronary failure — Duration: unknown
Due to: Hypertension — Duration: years.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles Lummedee M. D.
Address 900 W Lombard St. Date signed Aug. 17-1947.

BALTIMORE CITY HEALTH DEPARTMENT

54428 BC# D86233 **CERTIFICATE OF DEATH** 161a

Registered No. G54428

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 804 W. Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Waverly Williams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex: Male | 5 Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-13-47

8. AGE: Years | Months | Days 5 4 | If less than one day ___ hr. ___ min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Wilbagu Williams

13. Birthplace Va.

MOTHER 14. Maiden Name Doris Cuoko

15. Birthplace N.J.

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 20 47 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location Baltimore

18 (a) Funeral director Joseph L. Russ

(b) Address 1240 N. Mc Cullough

19 (a) AUG 19 1947 Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-17-47, at 835 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-17 1947 to 8-17 1947, and that I last saw h[im] alive on 8-17 1947.

Immediate cause of death	Duration
Asphyxia	
Due to Cardiac Failure	6-8 hours
Due to Sepsis	3 days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ruby Russ M. D.

Address Johns Hopkins Hosp. Date signed 8-19-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given. Please write the causes of death clearly and legibly. Be sure to give correct age if especially important. Physicians: please write your name and address.

V S 150

G54429 death

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. G54429

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Give correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen Hosp 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 935 W. Franklin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willie Willis Fuller

3 (b) If veteran, name war No 2 Yes

3 (c) Social Security Account No. 239-07-0039

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife Mable Fuller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 7-1910

8. AGE: Years	Months	Days	If less than one day
36 37	9	10	hr. min.

9. Birthplace Columbia S.C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Willie Fuller
13. Birthplace Laurence S.C.

MOTHER
14. Maiden Name Alma Boyston
15. Birthplace Laurence S.C.

16 (a) Informant Alma Henry
(b) Address 2110 Oak St Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 22 1947 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cemetery
Location Balto Md

18 (a) Funeral director Robert E. Williams
(b) Address 1545 McElderry St

19 (a) AUG 19 1947 (Date rec'd by registrar) (b) Huntingtown Williams, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 1947, at 10 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of abdomen with rupture of liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-17-47 at 9:00 P M.
(b) Where did injury occur Tavern 1950 Chesapeake Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? no
(d) Means of injury Firearms

23. Signature Earl L. Boyle M.D.
Medical Examiner
Date signed 8-18-47

G54430 LW 111851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G54430

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 205 W. Henretta St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth Deane

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-03-4397

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June, 9, 1914

8. AGE: Years	Months	Days	If less than one day
33	2	4	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Cook.

11. Industry or business

FATHER
12. Name Leonard Deane (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Hall (D)
15. Birthplace Md.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Aug 22-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Magothy
Location Arlington Rd

18 (a) Funeral director Robert E. Williams
(b) Address 1515 McElroy St

AUG 19 1947 (b) Huntington Md.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 18 19 47 at 5:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 2 19 47, to Aug. 18 19 47.
and that I last saw her alive on Aug. 18 19 47.

Immediate cause of death	Duration
Respiratory failure	4 da
Due to Tuberculosis Pulmonary far advanced	4 mo
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph J. Bowen Jr. M. D.
Address Balto City Hosp Date signed 8-18-47

G54431 BCH B70218

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G54431

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1005 N. Wolfe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Priscilla Harlee
3 (b) If veteran, name war
3 (c) Social Security Account No.
Sex: Female
5. Color or race: Col.
6 (a) Single, married, widowed, or divorced. ✓
6 (b) Name of husband or wife ✓
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 2-9-47
8. AGE: Years | Months 6 | Days 8 | If less than one day — hr. — min.
9. Birthplace Md. (Town) county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Harlee
13. Birthplace ?

MOTHER
14. Maiden Name Hattie ?
15. Birthplace ?

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Aug 12 1947 (month) (day) (year)
(c) Cemetery or crematory Matthews Chapel
Location Roland Heights Cemetery
18 (a) Funeral director Robert E Williams
(b) Address 1515 McElderry St
19 (a) AUG 10 1947 (Date received by Registrar) Washington Hollow, Md. (Registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-17-47, at 8A M

21. I certify that death occurred on the date above stated; that I attended deceased from 17 Aug 1947 to 1947, and that I last saw h[illegible] alive on 17 Aug 1947.

Immediate cause of death ? Septicemia —
Due to Child brought to accident room unrevived.
Due to died few minutes later
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Philip Brown M. D.
Address John Hopkins Hosp Date signed 17 Aug 47

X

G54432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G54432

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens ave
(c) Hospital or institution: St. agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Catonsville
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 116 oak Drive 28
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. C. Edwin appler -

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Brooke H. appler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 27, 1885

8. AGE: Years	Months	Days	If less than one day
62	6	22	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER — 12. Name	Decd Frank McCrea
FATHER — 13. Birthplace	Md
MOTHER — 14. Maiden Name	Decd Carrie F. Barsley
MOTHER — 15. Birthplace	Md.

16 (a) Informant Mr. Ellsworth Appler
(b) Address 7 Seminole Ave Catonsville Md
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/20/47 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Edmondson Ave Baltimore Md
18 (a) Funeral director Easton Sons
(b) Address 608 Fredericks Ave Catonsville Md

AUG 19 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150 Cameron Hospital

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-18- 1947, at 3:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-21 1947 to 8-18 1947 and that I last saw her alive on 8-18 1947

Immediate cause of death	Duration
1. Myocardial Failure	
2. Chronic Heart	
Due to Failure	
Due to 3. Nephrosis	
4. Scirrhosis of liver	
Other Conditions Fracture Hip Left	
5. Diabetes Mell. yes	

(Include pregnancy within 3 months of death)
Date of operation 7-25-47
Major findings of operation: Fracture Hip Left
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 7/18/47 at M
(c) Where did injury occur? Baltimore (City or town) (County) Md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work?
Means of injury Fell on floor.
23. Signature Hugh A Wells M. D.
Address Clapper's Hospital Date signed 8/19/47

Homer J. Mueller, M.D.

G54433

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

832a

G54433

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ala (b) County Jefferson
(c) City or town Bessemer
(If outside city or town limits, write RURAL and give town)
(d) Street No. 408 S 8th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country England

3 (a) FULL NAME Henry Halcyon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1904

8. AGE: Years	Months	Days	If less than one day
52 43	7	1	hr. min.

9. Birthplace Columbiana Alabama
(Town, county, and state)

10. Usual Occupation Merchant Marine

11. Industry or business

FATHER
12. Name John England
13. Birthplace Columbiana Ala.

MOTHER
14. Maiden Name Virginia Davis
15. Birthplace Columbiana, Ala

16 (a) Informant Mrs Margaret Barnes
(b) Address 408-8th St So Bessemer Ala

17 (a) Removal (b) Date thereof 8-19-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Bessemer - Ala.

18 (a) Funeral director Stewart Mowten Co.
(b) Address 1824 North Ave.

19 (a) AUG 19 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 17 1947, at 3:55 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage
Acute edema of lungs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George E. Merrill M.D.
Medical Examiner.
Date signed 8/18/47

(PLEASE WRITE PLAINLY, WITH INK. Give the causes of death clearly and legibly. Correct age is especially important. Physicians: please write this.)

VS 151

54434 Louis

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

G54434 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town ~~Bel~~ Abingdon
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis C Faber

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-12-8543

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Helen E. Faber

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/24/83

8. AGE: Years 64 | Months 10 | Days 23 | If less than one day ..... hr. ..... min.

63

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Car Inspector

11. Industry or business B. & O. Railroad

FATHER 12. Name Henry Faber

13. Birthplace Germany

MOTHER 14. Maiden Name Margaret Kane

15. Birthplace Baltimore, Md.

16 (a) Informant Betty J. Faber

(b) Address Abingdon, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 20, 1947 (month) (day) (year)

(c) Cemetery or crematory Trinity Lutheran

Location Joppa, Harford Co., Md.

18 (a) Funeral director H. K. McComas & Son

(b) Address Abingdon, Md.

19 (a) AUG 19 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16 1947, at 3:47 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebro Vascular Cardio-Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ..... at ..... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature William J. Helfrich M.D.
Medical Examiner.

Date signed Aug 16, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use typewriter if possible. Do not use abbreviations or ditto marks. Be sure to write the causes of death clearly and legibly. Do not state mode of dying, such as heart failure, asphyxia, or anemia, but the disease or injury which caused it. Omission to answer all questions or entering illegible or incorrect answers will necessitate return of certificate. Items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23 must be answered. Entry of correct age is especially important. Physicians: please write your name and address on the back of this certificate.

VS 151

G54435 Blk B-85825 BALTIMORE CITY HEALTH DEPARTMENT ✓ 159 Registered No. G54435

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 601 North Broadway
(c) Hospital or institution:
The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Turners' Station
(If outside city or town limits, write RURAL and give town)
(d) Street No. 513 Main Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Branch (Lillie)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		5	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name McKenzie Branch
13. Birthplace Virginia

MOTHER
14. Maiden Name Lillie Ingram
15. Birthplace Virginia

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School AUG 19 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) AUG 19 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 1947, at 12.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from August 10 1947, to August 15 1947, and that I last saw her alive on August 15 1947.

Immediate cause of death: Omphalitis with Septecemia and Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B.C Williams
B.C Williams, M.D., M. D.
Address Date signed 8-18-47

G54436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G54436
Registered No.

PLEASE WRITE PLAINLY, with UNFADING INK. Use the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 913 St. Barnabys Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIE GREEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years 45 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School AUG 19 1947

18 (a) Funeral director Commissioner of Health

(b) Address

AUG 19 1947 Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26, 1947, at 8.45 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fractured skull & intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 17/1

(a) Date of injury 7-25-47 at 8:00 P M.

(b) Where did injury occur? Front of 921 St. Barnabas Ct.

(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? no

(d) Means of injury Fell or struck head on sidewalk

23. Signature [signature] M.D.
Medical Examiner.

Date signed 7-26-47

X

C54437

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. C54437

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be answered. Do not write age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 748 McCabe Ave.
(c) Hospital or institution: 21
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 629 Wyeth St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Blanche Virginia Kirschbaum

3 (b) If veteran, name war —
3 (c) Social Security Account No. 220-18-7279

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Robert LeRoy Kirschbaum
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1912

8. AGE: Years 35 | Months 3 | Days 11 | If less than one day ... hr. ... min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At home

FATHER
12. Name Joseph A. Blackburn
13. Birthplace Virginia

MOTHER
14. Maiden Name Estelle Johnson
15. Birthplace Virginia

16 (a) Informant Robert LeRoy Kirschbaum
(b) Address 629 Wyeth St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Wed Aug 20, 1947 (month) (day) (year)
(c) Cemetery or crematory Druid Hill Park
Location Dolly Madison Entrance

18 (a) Funeral director A. Howard Evans
(b) Address 1402 Charles St.

19 (a) AUG 19 1947 (Date rec'd by registrar) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sun. Aug 17 1947, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1947 to Aug 17 1947, and that I last saw h[illegible] alive on Aug 17 1947

Immediate cause of death	Duration
Metastatic adenocarcinoma of right breast	15 months
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation May 31, 1946
Major findings of operation: carcinoma of breast
of autopsy: not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert F. Saunderheimer, Jr. M.D.
Address Riviera Apts. Lake Drive Date signed Aug 18, 1947
Saunderheimer

G54438

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G54438 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3505 Devonshire Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3505 Devonshire Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick L. C. Wehrenberg

3 (b) If veteran, name war ------

3 (c) Social Security Account No. 216-09-3840

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Florence M. nee Kent

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19, 1884

8. AGE: Years	Months	Days	If less than one day
63	4	29	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Insurance Business
11. Industry or business Broker

FATHER
12. Name Frederick L. C. Wehrenberg
13. Birthplace Germany

MOTHER
14. Maiden Name Whilimenia Suchting
15. Birthplace Germany

16 (a) Informant Mrs. Florence M. Wehrenberg
(b) Address 3505 Devonshire Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/20/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Loring Byers
(b) Address 5005 Park Heights Avenue

AUG 19 1947 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1947 at 6:A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 4 1947, to Aug 17 1947, and that I last saw him alive on Aug 17 1947.

Immediate cause of death	Duration
Coronary occlusion	3 hrs.
Due to Angina Pectoris	6 Mo.
Due to Coronary Sclerosis	4 yr.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sherryand Wantz M.D.
Address 2601 Maunsell Rd. Date signed 8/18/47

VS 150

Dr. Milton C. Lang
2117 Belair Rd.

G54439

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G54439

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Be sure to write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3114 Cliftmont Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3114 Cliftmont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Francis Mockabee

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-09-2784

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Grace E. Mockabee

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1881

8. AGE: Years 65 | Months 11 | Days 16 | If less than one day hr. min.

9. Birthplace Washington D. C. (Town, county, and state)

10. Usual Occupation Supervisor

11. Industry or business Bethlehem Shipbuilding

FATHER
12. Name Edgar F. Mockabee
13. Birthplace Wash. D. C.

MOTHER
14. Maiden Name Josephine A. Wood
15. Birthplace Wash. D. C.

16 (a) Informant Grace E. Mockabee
(b) Address 3114 Cliftmont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-20-47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Row St. & E. North Ave.

18 (a) Funeral director Wm. Cook Sons
(b) Address 1217 St. Paul St.

19 (a) AUG 19 1947 (Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-17- 1947, at 8 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-16- 1947 to 8-17- 1947 and that I last saw him alive on 8-17- 1947.

	Duration
Immediate cause of death: Cerebral Thrombosis	3 days
Due to: Hypertensive cardio-vascular Disease	2 yrs
Due to: Generalised Arteriosclerosis	?
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton C. Lang M. D.
Address 2117 Belair Rd Date signed 8-19-47

Huntington Williams, M.D.

G54440

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 95c

G54440 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital 18 - 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 840 W. Lombard Street
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME MARION HERBST

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: S

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1918

8. AGE: Years 28 | Months 10 | Days 29 | If less than one day .....hr. .....min.

9. Birthplace Portsmouth, Ohio
(Town, county, and state)

10. Usual Occupation Slitter

11. Industry or business Platt Paper Company

FATHER
12. Name John P. Herbst
13. Birthplace Ohio

MOTHER
14. Maiden Name Olive P. Fout
15. Birthplace Ohio

16 (a) Informant Melcher Funeral Home
(b) Address Portsmouth, Ohio

17 (a) removal (Burial, cremation, or removal) (b) Date thereof 8/19/47 (month) (day) (year)
(c) Cemetery or crematory Vernon
Location Portsmouth, Ohio

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) AUG 19 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16, 1947, at 5 05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute dilatation of heart
Acute edema of lungs
Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 8/18/47

G54441

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

Registered No. G54441

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2222 W. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days): 15-3
(e) Length of stay in Baltimore (yrs., mos., or days) 55 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2222 W. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHRISTOPHER LINGENFELDER

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Lillian A. Lingenfelder
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 20, 1891

8. AGE: Years	Months	Days	If less than one day
55	9	26	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Retired Fireman
11. Industry or business Balto. Fire Dept.

FATHER
12. Name John T. Lingenfelder
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Minnie Hamstafer
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Lillian A. Lingenfelder
(b) Address 2222 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/47 (month) (day) (year)
(c) Cemetery Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICHNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

19 (a) AUG 19 1947 (Registrar) (b) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16, 1947 19 , at 4:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to Aug 16 1947, and that I last saw h. alive on Aug 16 1947.

Immediate cause of death Carcinoma of Lung — Duration 1yr.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Eichman M.D.
Address 1926 North Ave Date signed 8/18/47 M.D.

54442

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V. 13 B

G54442
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3530 Hickory Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3530 Hickory Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Baggett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Married

6 (b) Name of husband or wife Bertha M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4, 1900

8. AGE: Years	Months	Days	If less than one day
47	4	14	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation Auto Mechanic
11. Industry or business Aristocrat Dairy

FATHER
12. Name James Baggett
13. Birthplace Virginia

MOTHER
14. Maiden Name Martha Bryant
15. Birthplace Virginia

16 (a) Informant Mr. Donald E. Baggett
(b) Address 3530 Hickory Avenue

17 (a) burial (b) Date thereof 8/21/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Madonna Gdns
Location Dorsey Md

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) Date rec'd by Registrar AUG 20 1947 (b) Registrar Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18, 1947, at 4:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946 to Aug 18 1947 and that I last saw h[illegible] alive on Aug 8 1947.

Immediate cause of death	Duration
Tuberculosis Both Lungs	7
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Laurence L. Pennell M. D.
Address 711 Fallsway Date signed 8-19-47

54443

LW 112926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

G54443
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 528 Scott St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Bessie Mae Balzek

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Smith.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4-1883

8. AGE: Years	Months	Days	If less than one day
64	3	13	hr. min.

9. Birthplace Martinsburg W.Va.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John L.Furley
13. Birthplace Hagerstown Md.

MOTHER
14. Maiden Name Ellan Chaney
15. Birthplace Williamsport, Md.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 8/21/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Wilson & Son
(b) Address 1214 N. Paul St.

19 (a) Date received by registrar AUG 20 1947 (b) Huntington Williamsport Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 17 19 47 at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 11 19 47 to Aug. 18 1947, and that I last saw Pr alive on Aug. 18 19 47

Immediate cause of death Hypertensive C-V Disease - Decompensated. — Duration

Due to

Due to

Other Conditions Bronchopneumonia. Lingipelar J Legs.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert A. Farber M. D.
Address Baldo City Hosp Date signed 8-19-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

54444

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V. G54447

183 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 West Street
(c) Hospital or institution:
City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State VA (b) County
(c) City or town Norfolk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1226 Bolton Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James A. Reaves

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Mal | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1928

8. AGE: Years 19 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Henry Reaves
13. Birthplace N. C.

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Henry Reaves
(b) Address Pitt. Co. N. C.

17 (a) (Burial, cremation, or removal) (b) Date thereof Aug. 22. 47 (month) (day) (year)
(c) Cemetery or crematory N. C.
Location Greenville. N. C.

18 (a) Funeral director Geo. G. Kilson
(b) Address 1303 Preston Ave. Lt.

AUG 20 1947 (Date rec'd by Reg'r) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 1947, at 5 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 26/6
(a) Date of injury 8/14/47 t M.
(b) Where did injury occur? Harbor #4 Anchorage Air-port
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? N.a.
(d) Means of injury Drowning

23. Signature Earl H. Royster M.D.
Medical Examiner
Date signed 8/19/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Enter the causes of death clearly and legibly. Physicians: please write correct age is especially important.

VS 181

X

G54445

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G54445 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5712 Cross Country Blvd.
(c) Hospital or institution: home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 15
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5712 Cross Country Blvd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Carrie Fowler Carman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Obe C. Carman
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 21, 1874

8. AGE: Years	Months	Days	If less than one day
73	1	28	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business " "

FATHER
12. Name Raisin Fowler
13. Birthplace ?- Ireland

MOTHER
14. Maiden Name Margaret Moore
15. Birthplace ?- Ireland

16 (a) Informant Mr. O. Wilton Carman- Son
(b) Address 5712 Cross Country Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 21 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director Stewart & Mourard Company
(b) Address 108 W. Northern Avenue

AUG 20 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19 1947, at 1 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 7 1947, to Aug 19 1947, and that I last saw h Er alive on Aug 16 1947.

Immediate cause of death	Duration
Cardiac decompensation	2 days.
Due to Chronic Myocarditis	1 year
Due to General arteriosclerosis	3 years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation —
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —
23. Signature Herbert F. Rieleman M. D.
Address 6 E Biddle St Date signed 8/21/47

54446

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

467

Registered No. G54446

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway + Fairmount Ave
(c) Hospital or institution: Church Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 710 N. Belnord Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Anna Blaha

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Joseph Blaha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29, 1886

8. AGE: Years 61 | Months 2 | Days 27 | If less than one day hr. min.

9. Birthplace Bohemia (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Patrin
13. Birthplace Bohemia

MOTHER
14. Maiden Name Anna Hench
15. Birthplace Bohemia

16 (a) Informant Mrs. Anna Blaha
(b) Address 710 N. Belnord Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/20/47 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Oak Hill
Location Horner's Lane, Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

AUG 20 1947 (Date filed) (Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1947, at 1:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 7, 1947 to Aug. 17 1947 and that I last saw her alive on Aug. 17 1947.

Immediate cause of death Peritonitis

Due to Carcinoma Rectum

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8-12-47

Major findings of operation: Abdomen - perineal resection coxe - rectum

of autopsy Confirmed - obstruction ileum

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Robert Haase M. D.
Address Church Home + Hosp. Date signed 8/22/47

G54447

BALTIMORE CITY HEALTH DEPARTMENT ✓ G54447

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident 19-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 432 N. Carey (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Della Henson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Edward Henson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22, 1892

8. AGE: Years 55 | Months 3 | Days 26 | If less than one day hr. min.

9. Birthplace Springfield, mass, (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Parson.
13. Birthplace ? Mass.

MOTHER
14. Maiden Name Martha West.
15. Birthplace Springfield Mass.

16 (a) Informant Genevieve Crittenton
(b) Address 432 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.
AUG 20 1947 (Date rec'd by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/18 1947, at 6 55 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/18 1947 to 8/18 1947 and that I last saw h.r alive on 8/18 1947.

Immediate cause of death Cerebrovascular Hemorrhage

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Paston Hurt M.D.
Address 1514 Division St Date signed 8/19/47

VS 150

X

54448

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

467

Registered No. G54448

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 20-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3123 Leeds St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jane Staples

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years	Months	Days	If less than one day
76			hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Sam Williams
13. Birthplace Md.

MOTHER
14. Maiden Name Mazie Dorsey
15. Birthplace Md.

16 (a) Informant Horace Staples
(b) Address 3123 Leeds St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-22-1947 (month) (day) (year)
(c) Cemetery or crematory Western Run
Location Catonsville Md.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St

AUG 20 1947

(a) (Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 17 1947 at 8:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 7 1947 to Aug. 17 1947 and that I last saw h[illegible] alive on Aug 17 1947.

Immediate cause of death Intestinal Obstruction — Duration

Due to Cause unknown

Due to

Other Conditions Ca Rectum; Abdominal Perineal Resection

(Include pregnancy within 3 months of death)

Date of operation 8-14-47

Major findings of operation: Carcinoma of Rectum

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert C. Hunter, M.D. M. D.

Address Univ. Hosp. Date signed 8-17-47

X

G54449

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G54449 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 11
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 907 Linden ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eugene Gray

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	N	

6 (b) Name of husband or wife Louise

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 27, 1882

8. AGE: Years	Months	Days	If less than one day
65	6	22	hr. min.

9. Birthplace Anne Arundel Co. Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Wm. De Coursey Friend
(b) Address 339 Camel St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 W. Lexington St.

19 (Date rec'd by registrar) AUG 20 1947 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 August 1947, at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 15 Aug 1947 to 18 Aug 1947, and that I last saw him alive on 18 Aug 1947.

Immediate cause of death Bronchopneumonia — Duration 1 day

Due to General debility

Due to malnutrition

Other Conditions Hemiplegia, rt. due to cerebral Hemorrhage in 1945
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank J. Brady M. D.
Address Md. Gen. Hosp. Date signed 8-18-47

for Dr. B. Belfort
#22 - Medders, M.D. 107 E.

54450

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

✓ G54450 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) ½ day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1144 Myrtle ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Reynolds

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1927

8. AGE: Years	Months	Days	If less than one day
20			hr. min.

9. Birthplace Camden, S.C.
(Town, county, and state)

10. Usual Occupation maid

11. Industry or business

FATHER
12. Name Timothy Reynolds
13. Birthplace Camden, S.C.

MOTHER
14. Maiden Name Ada Davis
15. Birthplace Camden, S.C.

16 (a) Informant Mrs. Maggie Reynolds
(b) Address 1144 Myrtle Ave.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 8-21-1947 (month) (day) (year)

(c) Cemetery or crematory
Location Camden, S.C.

18 (a) Funeral director Mrs. K. R. Williams
(b) Address 322 N. Schroeder St

19 (a) AUG 20 1947 (Date rec'd) (b) Huntington Williams Mortuary Registered

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 1947, at 10 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pulmonary edema
Acute fatty degeneration of liver

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Foyer M.D.
Medical Examiner.
Date signed 8-18-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Be sure the causes of death clearly and legibly. correct age is especially important. Physicians: please write the

G54451

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167

G54451
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1814 Laurens St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Chase

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: 7

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Separated

6 (b) Name of husband or wife Melvin Chase

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1911

8. AGE: Years 36 | Months | Days | If less than one day hr. min.

9. Birthplace Calvert Co. Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name John W Chase
13. Birthplace Calvert Co. Md

MOTHER
14. Maiden Name Minnie Makel
15. Birthplace Calvert Co. Md.

16 (a) Informant Sarah Chase
(b) Address 1211 Mosher St

17 (a) Burial (b) Date thereof 8/22/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Portupent Chapel.
Location Huntingtown Calvert Co. Md.

18 (a) Funeral director Metropolitan Funeral Home Inc.
(b) Address 921 N. Mount St.

AUG 20 1947 (Date received by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-18- 1947, at 9 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH
Stab-wound of right chest
Hemorrhage into rt. chest cavity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-17-47 at 3 P.M.
(b) Where did injury occur? 1814 Laurens St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury. Stabbed with knife.

23. Signature George E. Merrill M.D.
Medical Examiner.
Date signed 8-19-47

54352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G54452
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland SUPERINTENDENT'S HOME
(b) Street address CLIFTON PARK
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 79-6

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE CITY
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town) SUPERINTENDENT'S HOME
(d) Street No. CLIFTON PARK. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) **FULL NAME** GEORGE HENRY WEYER SR.

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED.

6 (b) Name of ~~husband~~ or wife LILLIE M. WEYER
6 (c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) FEB. 27 1868

8. AGE: Years	Months	Days	If less than one day
79	5	21	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation DRAFTSMAN
11. Industry or business BOILER MAKERS

FATHER
12. Name JOHN WEYER
13. Birthplace BALTIMORE, MD

MOTHER
14. Maiden Name ELIZABETH (?)
15. Birthplace BALTIMORE, MD.

16 (a) Informant JOHN F. WEYER (SON)
(b) Address NORTHWOOD APTS.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/47 (month) (day) (year)
(c) Cemetery or crematory WESTERN.
Location Edmondson Avenue

18 (a) Funeral director Chas. J. Cranwell Son, Inc.
(b) Address 118 N. Mt. Royal Ave

19 AUG 20 1947 (Date rec'd by Local Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 18, 1947, at 9 15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from MAY 21, 1947 to AUG. 18 1947, and that I last saw HIM alive on AUG. 18, 1947.

Immediate cause of death HEART BLOCK — Duration 11 Hrs, 1946

Due to ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE — YEARS

Due to GENERALIZED ARTERIOSCLEROSIS — MAY, 1941

Other Conditions GASTRIC MALIGNANCY (?)
(Include pregnancy within 3 months of death)

Date of operation NONE.
Major findings of operation:

of autopsy: NO AUTOPSY

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur Karfgin M. D.
Address 4230 York Road Date signed 5-18-47

X

21453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93-D

Registered No. G54453

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. Write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey St
(c) Hospital or institution: Good Samaritan Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2025 McElderry St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME David Roppe(ltor) Davie Roppert

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-07-9996

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of ~~husband~~ or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 23 1868

8. AGE: Years	Months	Days	If less than one day
78	11	26	hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Paper Hanger

FATHER
12. Name David K Roppert
13. Birthplace Balto

MOTHER
14. Maiden Name Elizabeth
15. Birthplace Balto

16 (a) Informant August Roppert
(b) Address 2025 McElderry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 22 47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4300 Belair Rd

18 (a) Funeral director Martin W.E. Duppel's Sons
(b) Address 37 S Ann St 31

AUG 20 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19 1947, at 9:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 12 1947, to Aug. 19 1947, and that I last saw h~~im~~ alive on Aug 18 1947.

Immediate cause of death	Duration
Acute Cardiac failure	2 days.
Due to Arteriosclerotic heart disease	years.
Due to	
Other Conditions Gangrene of both feet	months.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Tammaselle M. D.
Address 910 W. Lombard St Date signed Aug 20 1947.

G54454

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

LW 110084

G54454 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 136 S. Curley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Miller (William Frederick Miller)

3 (b) If veteran, name war: NONE

3 (c) Social Security Account No. 214-03-7480

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ellen C. (Finnerty) Miller

6 (c) If alive, give age → years

7. Birth date of deceased (mo., day, yr.) Feb. 29, 1888

8. AGE: Years 59 | Months ✓ | Days 20 | If less than one day ... hr. ... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER
12. Name Joan Miller
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Race
15. Birthplace Germany

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Henry Sander's Sons, Inc.
(b) Address North Ave & Broadway

19 (a) Date received by registrar AUG 20 1947 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 18 1947, at 12:15 M A

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 21 1947 to Aug. 18 1947 and that I last saw him alive on Aug. 18 1947.

	Duration
Immediate cause of death: Respiratory failure	1 wk
Due to: Tuberculosis of lungs far advanced	8 mos
Due to:	
Other Conditions: Arteriosclerosis, Pulmonary Emphysema	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph Bowen Jr M.D.
Address Balto City Hosp Date signed 8-18-47

C54455

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. C54455

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 3307 Dudley Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 - 3
(e) Length of stay in Baltimore (yrs., mos., or days) 88 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3307 Dudley Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNIE AULT

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None
4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: John Ault
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): July 17, 1858
8. AGE: Years: 89 Months: 1 Days: 1 If less than one day: hr. min.
9. Birthplace: Norfolk, Va. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:

FATHER
12. Name: ? Ruhwadel
13. Birthplace: Germany

MOTHER
14. Maiden Name: Elizabeth Dietz
15. Birthplace: Germany

16 (a) Informant: Harry W. Werntz
(b) Address: 3307 Dudley Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/47 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

AUG 20 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION AM

20. DATE OF DEATH August 18 1947, at 10.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1946, to Aug 18 1947 and that I last saw h alive on Aug 12 1947.

Immediate cause of death	Duration
Acute Cardiac Failure	
Due to Arteriosclerotic Cardio-Vascular Renal Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: H. W. Stevens M.D.
Address: 340 W. Saratoga St. Date signed: 8/19/47

G54456 Dr Lr Klimes
2623 E. Monument

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

59B

Registered No. G54456

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3111 Southern Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3111 Southern Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SALLIE J. TWOMEY

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife William J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7, 1874

8. AGE: Years	Months	Days	If less than one day
73	3	12	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name George A. Dean
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth J. Devlin
15. Birthplace Md.

16 (a) Informant Mr. William J. Twomey
(b) Address 3111 Southern Avenue

17 (a) Burial (b) Date thereof 8/21/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

AUG 20 1947 (b) Huntington Williams Md.
(Date rec'd by Registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 19, 1947, at 11 45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1947, to Aug 19 1947, and that I last saw h[illegible] alive on Aug 19 1947.

Immediate cause of death Myocardial failure — Duration 6 weeks ?
Hypertrophic Arthritis
Due to Arteriosclerosis generalized ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James J. Klimes M. D.
Address 2623 E. Monument St Date signed 8/19/47

X

G54457 M. Sodaro
4622 York Road

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

Registered No. G54457

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.
PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4203 Powell Avenue
(c) Hospital or institution: 26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4203 Powell Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ORIN KING RAGLAND

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-24-0782

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Rose Seidel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10, 1888

8. AGE: Years	Months	Days	If less than one day
59	4	8	hr. min.

9. Birthplace Oxford, North Carolina
(Town, county, and state)
10. Usual Occupation Bartender
11. Industry or business

FATHER
12. Name Robert Ragland
13. Birthplace N.C.

MOTHER
14. Maiden Name ?
15 Birthplace ?

16 (a) Informant Mrs. Rose S. Ragland
(b) Address 4203 Powell Avenue

17 (a) Burial (b) Date thereof 8/21/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Maryland

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, [illegible]

Filed [illegible] 20 1947 Hampton Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG. 18th, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 12 1947 to Aug 15 1947, and that I last saw him alive on Aug 15 1947

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Manuel Sodaro M. D.
Address 4624 York Road Date signed Aug 20

G54458

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52a

Registered No. G54458

MARGIN RESERVED — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton + Wilkens Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1316 Elm Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Anna Mc Clintock ANNA H. McCLINTOCK

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow M.

6 (b) Name of husband or wife: Elmer E. McClintock
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1866

8. AGE: Years	Months	Days	If less than one day:
71	8	27	hr. 5 min.

9. Birthplace Pa. Bedford Co., Pa. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name (dec'd) Conrad Shaffer
13. Birthplace Germany

MOTHER
14. Maiden Name (dec'd) Mary Evans
15. Birthplace Pa.

16 (a) Informant Mrs. Ida E. McCauley
(b) Address 1316 Elm Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/47 (month) (da (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto. Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

19 AUG 20 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-20 1947 at 1-45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 8/20 1947. and that I last saw her alive on 8/20 1947

Immediate cause of death Cardiac failure — Duration
Due to Pulmonary fibrosis — Duration
Due to Hypertensive nephrosclerosis — Duration
Due to Arteriosclerosis — Duration
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 8/20/47

G54459

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 186a

G54459 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Md. General Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) ~~13 days~~
(e) Length of stay in Baltimore (yrs., mos., or days) 82 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6012 York Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ella D. Boyer ELLA DAULGREN BOYER

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Geo. — Boyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1864

8. AGE: Years	Months	Days	If less than one day
82	11	11	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Chief Clerk Retired
11. Industry or business B. & O. R. R.

FATHER 12. Name Robert Henry Bradley
13. Birthplace Md. Balto.

MOTHER 14. Maiden Name Matelda Jones
15. Birthplace Md. Balto.

16 (a) Informant Mrs. Michael V. Conto
(b) Address 6012 York Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/22/47 (month) (day) (year)
(c) Cemetery ~~accidentally~~ Loudon Pk. Cem.
Location Balto. Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17. Md.

19 (a) Filed 8 20 1947 (b) Huntington Williamson
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/19 1947, at 2.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/26 1947 to 8/19 1947 and that I last saw h alive on 8/19 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to Hypostatic pneumonia	Senility
Due to fractured left femur.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 7/28/47
Major findings of operation: Fract. fem. (concentric of Stemmann pin
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 27/12
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 7/16 & 7/26 at M
(c) Where did injury occur? Balto Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home While at work? no
(Specify type of place)
(e) Means of injury fell in bath room floor

23. Signature J. T. Mitchell M. D.
Address Md. Gen. Hosp. Date signed 8/19/47

To be Worked Upon by Howard J. Greene, M.D. X

G54460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. G54460

The Every item of information should be carefully supplied. write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 8 2
(e) Length of stay in Baltimore (yrs., mos., or days) 51yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1902 N. Patterson Park Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John Lewis Schaefer

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-03-7612

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Mabel Arline Schaefer
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) 3-9-1896

8. AGE: Years 51 | Months 5 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Florist

11. Industry or business Florist

FATHER 12. Name John H. Schaefer
13. Birthplace Baltimore County

MOTHER 14. Maiden Name Rosa Quick
15. Birthplace Baltimore County

16 (a) Informant Mabel L. Schaefer
(b) Address 1902 N Patterson Park Ave.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 8-22-47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director John C. Miller Inc
(b) Address 2435 E. Oliver St

19 (a) AUG 20 1947 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 August 1947 at 9:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 16 Aug 1947 to 18 Aug 1947 and that I last saw him alive on 18 Aug 1947

Immediate cause of death	Duration
Hemetemesis & melena	3 day
Due to Ruptured esophageal Varices	3 days
Due to Cirrhosis of Liver	2
Other Conditions none	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard Casey, M.D.
Address Mercy Hospital Date signed 8/18/47

G54461 BC# 85711

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 64

G54461 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 17-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 Argyle Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Diane Hairston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. Baby

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1947 7/25/47

8. AGE: Years | Months: 1 0 | Days: 25 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Baby

11. Industry or business

FATHER
12. Name Frank Hairston
13. Birthplace North Carolina

MOTHER
14. Maiden Name Christine Ruff
15. Birthplace Baltimore, Md.

16 (a) Informant Christine Ruff
(b) Address 1303 Argyle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 AUG 20 1947 (Date rec'd by registrar) Huntington Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19, 1947, at 12.30 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Partial atelectasis
Hypertrophy of heart
Upper respiratory infection
Enlarged thymus
Due to

Other Conditions General enlarged nodes of omentum and mesentery
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Masters M.D.
Medical Examiner.
Date signed 8-19-47

G54462

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 125B

G54462 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 -
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 239 Spring Ct. - (If rural-route location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie Brady

3 (b) If veteran, name war -
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Widowed

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-27-80

8. AGE: Years	Months	Days	If less than one day
67	1	22	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Stephen Thompson
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Pinkett
15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 22-47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location Brooklyn, Md.

18 (a) Funeral director Elroy S. Wilson
(b) AUG 20 1947 Baltimore, Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 18 1947, at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 1947, to Aug. 18 1947 and that I last saw h[illegible] alive on Aug 18 1947

Immediate cause of death	Duration
Hepatitis, Infectious ??	2 mo
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Johns Hopkins Hosp. Date signed Aug 22 1947

G54463

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G54463
Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminister
(If outside city or town limits, write RURAL and give town)
(d) Street No. 54 E Main St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME GARVER, Walter Leroy

3 (b) If veteran, name war	3 (c) Social Security Account No.
WW II	?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	single

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-5-19

8. AGE: Years	Months	Days	If less than one day
27	10	15	hr. min.

9. Birthplace New Winsor, Carroll Co., Md.
(Town, county, and state)
10. Usual Occupation upholsterer
11. Industry or business -

FATHER
12. Name GARVER, Jessie
13. Birthplace Maryland

MOTHER
14. Maiden Name BEAVER, Theodocia
15. Birthplace Maryland

16 (a) Informant Records
(b) Address U. S. Marine Hospital

17 (a) Burial (b) Date thereof Aug-23-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Westminster Cem-
Location Westminster, Md.

18 (a) Funeral director J. E. Myers, Jr.
(b) Address Westminster, Md.

AUG 21 1947
(Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20, 1947, at 8:45A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 17 1947 to Aug. 20 1947 and that I last saw him alive on August 20, 1947

Immediate cause of death Rupture of congenital aneurysm of circle of Willis. — Duration 6 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marion Friedman, S.A. Surgeon, U.S.P.H.S.
Address US Marine Hospital Date signed 8-20-47
Baltimore, Maryland

G54464

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1634

G54464 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits write RURAL and give town)
(d) Street No. 3435 Elmley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Schramm

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Bernard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2 1872

8. AGE: Years 74 | Months 11 | Days 17 | If less than one day hr. min.

9. Birthplace Frederick Co Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Storms
13. Birthplace Frederick Co Md

MOTHER 14. Maiden Name Rachel Kanze
15. Birthplace Frederick Co Md

16 (a) Informant Mrs Norton Hoover
(b) Address 3435 Elmley Ave

17 (a) Burial Date of removal (Burial, cremation, or removal) (b) Date thereof Aug 21 47 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director M C Dorf
(b) Address 1219 E Fort Ave

19 (a) AUG 21 1947 (Date received by Registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19 1947 at 5:10 P.M.

21. I certify that I took charge of the remains described above, held an Aug 21 Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to illuminating gas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Aug 19, 1947 at 5:00 P.M.
(b) Where did injury occur? 3435 Elmley Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Took Open gas burners at Kitchen Range

23. Signature William L Pickrich M.D. Medical Examiner.
Date signed Aug 19, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information known to attendant should be entered. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54465

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 47

G54465 Registered No.

CM. 112583

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE.
(c) Hospital or institution: Balto. City Hospitals 21-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1305 Glyndon AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Mae Swift

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 20 -1877

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace MD.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles ?
13. Birthplace MD.

MOTHER
14. Maiden Name Barbara ? Allen
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern AVE.

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 8/21/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore MD

18 (a) Funeral director Wilson Funeral Home
(b) Address 1214 Druid Park Dr.

AUG 21 1947 (Date received by registrar) (b) Huntington for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 19 - 1947, at 3.30P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-29-47 1947 to Aug. 19 - 1947, and that I last saw her alive on Aug. 19 1947

	Duration
Immediate cause of death Paralytic Ileus with Peritonitis	
Due to Carcinoma of the Recto-sigmoid junction	36 hrs
Due to with metastases	8 mos
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Ca of Recto-sigmoid
Major findings of operation: junction
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank S. Parrott M.D.
Address Baltimore City Hospitals Date signed 8/19/47

Parrott X

G54466

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 124 B

Registered No. G54466

MARGIN RESERVED. Every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 239 S. Ellwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-2
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 239 S. Ellwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Milton E. King

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Hester

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Jan. 14

8. AGE: Years 52. | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Penn Cleaning Co

FATHER 12. Name Wm. H. King

13. Birthplace Balto Co.

MOTHER 14. Maiden Name Mary E. Hughes

15. Birthplace Balto Co.

16 (a) Informant Hester E. King.

(b) Address 239 S. Ellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 22. 47 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Custer Ave

18 (a) Funeral director L. HECKMANN & SON

(b) Address 6067 HARFORD Rd.

AUG 21 1947 (Signature of registrar) Huntington Hillsboro, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19. 1947 at 9 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1947 to Aug. 19 1947.
and that I last saw him alive on Aug. 18 1947.

Immediate cause of death Coronary Thrombosis

Due to Coronary Heart disease

Due to Arteriosclerosis

Other Conditions Cardiac Cirrhosis of Liver

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
3 days
3-4 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Chas. E. Douglas M. D.
Address 700 W. Lafayette Ave Date signed 8-20-47

937

54467.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G54467.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure to correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Monument & Rutland Ave
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days): 15 4
(e) Length of stay in Baltimore (yrs., mos., or days): 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County:
(c) City or town: Balto (If outside city or town limits, write RURAL and give town)
(d) Street No.: 2112 N. Pulaski St (If rural give location)
(e) Citizen of foreign country?: (Yes or No)
If yes, name country:

3 (a) **FULL NAME:** HERMAN GOLDBERG

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rebecca

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1878

8. AGE: Years: 68 | Months: | Days: | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation:

11. Industry or business: Oil Business

FATHER
12. Name: Hirsch Goldberg
13. Birthplace: Russia

MOTHER
14. Maiden Name: Dora ?
15. Birthplace: Russia

16 (a) Informant: Mr Joseph Silver
(b) Address: 2112 N Pulaski St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug, 21, 1947 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Rosedale Cem
Location: Hamilton Ave

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

(a) Date rec'd: AUG 21 1947 (b) Registrar: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/20/1947, at 7 24 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/13/1947 to 8/20/1947, and that I last saw h[illegible] alive on 8/20/1947.

Immediate cause of death	Duration
Myocardial Insuff.	
Due to: Myocardial infarction	
Due to: Coronary thrombosis	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?: (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?: While at work?: (Specify type of place)
(e) Means of injury:

23. Signature: Irma Cohn M. D.

Address: Sinai Hosp Date signed: 8/22/47

X

G54468

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G54468

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Avenue,
(c) Hospital or institution: Edgewood Nursing Home,
(d) Length of stay in hospital or inst. (yrs., mos., or days) about 5 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town 3 (If outside city or town limits, write RURAL and give town)
(d) Street No. 401 E. 25th. St., (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Murgatroyd

3 (b) If veteran, name war ---

3 (c) Social Security Account No. none

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife George W. Murgatroyd
6 (c) If alive, give age ___ years

7. Birth date of deceased (mo., day, yr.) April 13, 1863.

8. AGE: Years 84 | Months 4 | Days 4 | If less than one day ___ hr. ___ min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business ---

FATHER
12. Name William Mettee
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Dr. Geo. W. Murgatroyd
(b) Address 401 E. 25th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto 23rd.

18 (a) Funeral director E. J. Fleming & Son
(b) Address 1938 E. Lafayette Ave.

(a) (Date received) (b) (Registrar) Huntington Williams, M.D.

AUG 21 1947

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 18th. 1947, at 12 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 5th. 1947 to Aug. 18th. 1947.
and that I last saw her alive on Aug. 17th. 1947.

	Duration
Immediate cause of death: Cerebral Hemmorhage	2½ days
Due to: Arteriosclerosis	unknown
Due to: ---	
Other Conditions: Myocarditis	unknown

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George W. Murgatroyd M. D.
Address 3301 N. Charles St. Date signed 8/20/47

83a

C54469

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C54469 Registered No.

MARGIN RESERVED FOR USE OF REGISTRAR. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1337 Hanover St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1337 Hanover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John G. Miller

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 22 - 1914

8. AGE: Years 33 | Months | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name Geo. Wm. Miller
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Margaret M. Klein
15. Birthplace Balto Co. Md.

16 (a) Informant Charles Wm. Miller
(b) Address 1337 Hanover St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-23-47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem
Location Md

18 (a) Funeral director Bernard C Herle
(b) Address 121 E West St

AUG 21 1947 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 20 1947 at 2.05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h alive on 19

Immediate cause of death Epilepsy — Duration 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis T. Levy M. D.
Address 1844 W North Ave Date signed 8/20/47

(over)

C54470

G54470

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G54470

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1270 N Broadway
(If rural give location)
(e) Citizen of foreign country? ——— (Yes or No)
If yes, name country —

3 (a) FULL NAME Mr. Robert Brannon.

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mrs Maude A Brannon.
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Oct 15, 1880

8. AGE: Years 66 | Months 10 | Days 5 | If less than one day ... hr. ... min.

9. Birthplace Delaware.
(Town, county, and state)

10. Usual Occupation Painter
11. Industry or business Painter

FATHER
12. Name George Brannon
13. Birthplace Delaware.

MOTHER
14. Maiden Name Mary Betty
15. Birthplace Delaware

16 (a) Informant Mrs Maude A Brannon
(b) Address 1304 N Broadway, Balto

17 (a) Burial (b) Date thereof 8/23/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. North Ave. & Rose

18 (a) Funeral director Clarence E. Hoffmann
(b) Address 1639 N. Broadway

19 (a) ... (b) ...
(Date received by registrar) (Registrar)

AUG 21 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 20 1947, at 9½ A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 11, 1947, to Aug 20 1947, and that I last saw h alive on Aug 20 1947.

	Duration
Immediate cause of death Infarction of myocardium due to arteriosclerotic coronary thrombosis.	11 days.
Due to Arteriosclerotic heart disease	10 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Buchanan M. D.
Address Church Home & Hosp Date signed 8/20/47

X

G54471

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G54471
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & St
(c) Hospital or institution: Sinai 27
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4830 Belair Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MICHEAL [redacted] MARKIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Shoe Maker

11. Industry or business

FATHER
12. Name Philep
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah
15. Birthplace Russia

16 (a) Informant Anna Markin
(b) Address 4830 Belair Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-47 (month) (day) (year)
(c) Cemetery or crematory Ohr Israel
Location Loudoun Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2166 Eutaw Place

19 (a) (Date received) (Registrar) Huntington Williams M.D. Registrar

AUG 1 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/21 (8/21) 1947, at 1:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/15 1947, to 8/21 1947, and that I last saw h[illegible] alive on 8/21 1947.

Immediate cause of death Carcinoma of Stomach — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice A. Berelli
Address Sinai Hosp. Date signed 8/22/47 M. D.

G54172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. G54172

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital 19 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 320 S. Fulton Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD REYNOLDS

3 (b) If veteran, name war: World War II
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) aug. 14, 1927

8. AGE: Years	Months	Days	If less than one day
20		5	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business Baltimore Corrugating Co.

FATHER
12. Name William H. Reynolds
13. Birthplace Md.

MOTHER
14. Maiden Name Annie E. Snyder
15. Birthplace Md.

16 (a) Informant Wm. H. Reynolds
(b) Address 320 S. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-23-47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director George A. Farley
(b) Address Fulton Ave & Fayette St.

AUG 21 1947 (Date rec'd by registrar) (Certificate for Williams, M.D.)

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19, 1947, at 3.15 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hunter Generalized Peritonitis

Due to Perforation of Abscess.

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-17-47 at 2.05 A. M. Rt. #40- Middle River, Maryland.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Driver- Motorcycle-ran into auto

23. Signature [signature] M.D. (Medical Examiner)
Date signed 8-20-47

G54473

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓469

G54473
Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene St
(c) Hospital or institution: University Hospital 27-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6½ days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2911 Shirley ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** JAMES GORDON BENNETT

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Mamie A
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-14-1884

8. **AGE:** Years 62 | Months 10 | Days 6 | If less than one day ... hr. ... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Railroad - B & O

FATHER
12. Name Franklin P. Bennett
13. Birthplace Maryland

MOTHER
14. Maiden Name Lydia S. Lynch
15. Birthplace Maryland

16 (a) Informant Wife
(b) Address 2911 Shirley Ave. Balt. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Md.

18 (a) Funeral director Leonard J. Luck
(b) Address 5305 Harford Rd.

19 (a) AUG 21 1947 (Date received by Local Reg.) (b) Huntington Woll... W. Va.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 20 1947 at 2:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1947 to Aug 20 1947, and that I last saw h[illegible] alive on Aug 20 1947.

	Duration
Immediate cause of death Peripheral Circulatory Collapse	1 hr
Due to Postoperative conditions	2 days
Fatty degeneration	months
Due to Extensive carcinoma Pancreas & liver	years
Other Conditions Rheumatic valvulitis.	years

(Include pregnancy within 3 months of death)
Date of operation Aug 14, 1947
Major findings of operation: Inoperable
of autopsy: Carcinoma Pancreas Lamb

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Coryanny Jr. M.D.
Address University Hosp. Date signed 8/22/47

G54474

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G54474
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5404 Catalpha Road
(c) Hospital or institution:
27
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
6
(d) Street No. 5404 Catalpha Road
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Numa E. Morris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Claudia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1 - 1874

8. AGE: Years: 73 | Months: 3 | Days: 19 | If less than one day: hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business

FATHER
12. Name John Morris
13. Birthplace N.C.

MOTHER
14. Maiden Name Sarah Thompson
15. Birthplace N.C.

16 (a) Informant Dr Johnson

(b) Address 5404 Catalpha Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/1/47 (month) (day) (year)

(c) Cemetery or crematory Denton Cem.

Location Denton, North Dorchester

18 (a) Funeral director Leonard J. Ruck

(b) Address 5305 Harford Rd.

(c) AUG 21 1947 (Date rec'd by registrar) (Signature of Registrar) Williams M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20, 1947 at 2 10 P M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereof and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Walden M.D.
Medical Examiner.
Date signed 8-20-47

G54475 BC# G-81894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G54475 Registered No.

Every item of information should be carefully supplied. Do not write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 10-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 717 Aisquith Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carolyn (Caroline) D. Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age 23 years

7. Birth date of deceased (mo., day, yr.) June 29 1947

8. AGE: Years	Months	Days	If less than one day
	1 (2)	28 29	hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Williams
13. Birthplace

MOTHER
14. Maiden Name Viona Nicholson
15. Birthplace

16 (a) Informant Robert Williams
(b) Address 717 Asquith St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 21 47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location a.a. County Md.

18 (a) Funeral director Mrs Robt A Elliott Dy
(b) Address 1129 N. Carolina St.

AUG 21 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 20 19th 1947, at P. M

21. I certify that I took charge of the remains described above, held an Inspection and Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Lobar pneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 8/20/47

G54476

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G54476 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 412 N. Carrollton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18-2
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 412 N. Carrollton Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Martha Brown Lancaster

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-4383

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	colored	married

6 (b) Name of husband or wife Bernard Lancaster
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) April 29, 1893

8. AGE: Years	Months	Days	If less than one day
54	3	21/30	hr. min.

9. Birthplace Wilmington, N.C.
(town, county, and state)
10. Usual Occupation Presser
11. Industry or business Clothing factory

FATHER
12. Name George Brown
13. Birthplace Wilmington, N. Carolina

MOTHER
14. Maiden Name Amline Waddell
15. Birthplace Wilmington, N. Carolina

16 (a) Informant Bernard Lancaster
(b) Address 412 N. Carrollton ave

17 (a) Burial (b) Date thereof Aug. 23 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) AUG 21 1947 Wilmington Williams M.D.
(Registered by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8.19.47 19 8.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3.26.47 19 to 8.19.47 19, and that I last saw her alive on 8.19.47 19

Immediate cause of death	Duration
Cerebral Hemorrhage	few hours
Due to Arteriosclerosis	1945
Due to Cardiorenal vascular disease	1945
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James M. Kerr M. D.
Address 412 N. Carrollton Date signed 8.20.47

VS 8

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54477

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G54477

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: CHURCH HOME AND HOSPITAL
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 7
(e) Length of stay in Baltimore (yrs., ~~mos., or days~~) 79

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore 24, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3 S. Linwood Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Barbara Wallenweber (BARBARA WOLLENWEBER)

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: — none

4. Sex: F
5. Color or race: W
6 (a) Single, married, ~~widowed~~ or divorced: Charles
6 (b) Name of husband or wife: (John) Wallenweber
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 2, 1868

8. AGE: Years 79 | Months 7 | Days 18 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Siegelin
13. Birthplace Germany

MOTHER
14. Maiden Name Dorothy Muller
15. Birthplace Germany

16 (a) Informant Charles W. Schumacher
(b) Address 3 S Linwood, Balto Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/22/47 (month) (day) (year)
(c) Cemetery or crematory Trinity
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE & BROADWAY

19 (a) Date rec'd by registrar AUG 21 1947 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 Aug 1947, at 1:00 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 15 Aug 1947, to 20 Aug 1947, and that I last saw h~~er~~ alive on 19 Aug 1947.

Immediate cause of death	Duration
Anoxia	
Due to Myocardial degeneration	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 16 Aug 47
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard M. Garrett M. D.
Address Church Home + Hosp. Date signed 20 Aug 47

X

G54478

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

127a

Registered No. G54478

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE, MD (If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 BELT ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Kate Stiner

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Geo. W.
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Sept 19, 1870

8. AGE: Years	Months	Days	If less than one day
76	11	-	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name UNKNOWN
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant MRS. WALTER W. MARSH
(b) Address ANNAPOLIS P.O. ROUTE 2

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8 23 47 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location FREDERICK AVE.

18 (a) Funeral director JOHN F. DENNY, INC.
(b) Address 715 LIGHT ST.

AUG 21 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19 1947, at 5:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 24 1947, to Aug. 19 1947, and that I last saw he alive on Aug. 19 1947.

Immediate cause of death	Duration
Respiratory Failure secondary to Congestive Failure of Heart.	
Due to Hypertensive Arteriosclerotic Heart Disease.	5 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation July 24, 1947.
Major findings of operation: Empyema of Gall-bladder
of autopsy: Not done.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. A. Hildebrandt M. D.
Address 1213 Light St. Date signed 8-19-47

G54479

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51 B

Registered No. G54479

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 N. Broadway
(c) Hospital or institution: Church Home and Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 6

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore 12
(If outside city or town limits, write RURAL and give town)
(d) Street No. 207 Walker Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MR. George V. HUNT

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 157-03-9149

4. Sex: MALE

5. Color or race: White

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Minnie [illegible]

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1866

8. AGE: Years 81 | Months 2 | Days 11 | If less than one day hr. min.

9. Birthplace New Jersey
(Town, county and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Thomas Hunt
13. Birthplace New Jersey

MOTHER
14. Maiden Name Susan Clarkson
15. Birthplace New Jersey

16 (a) Informant Mrs. Florence Sawyer
(b) Address 207 Walker Ave., Balto, Md

17 (a) Removed (b) Date thereof 8/21/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory EWING CHURCH
Location TREATON N.J.

18 (a) Funeral director Williams & Son
(b) Address 1314 N. Point St.

19 AUG 21 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21 1947, at 8:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1947 to Aug 21 1947, and that I last saw him alive on Aug 21 1947

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Severe arteriosclerosis	
Cardio-vascular disease	
Due to	
Other Conditions Carcinoma, prostate	
Fracture, Compression, 1st L. vert.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lee M. Howard M. D.
Address [illegible] Church Home & Hosp. Date signed 8/21/47

VS 150

X (over)

G54480

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G54480

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1213 Light St

(c) Hospital or institution: South Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days

(e) Length of stay in Baltimore (yrs., mos., or days) 67 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 813 Unetta Ave (If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME Celia Davis. "CELIA K. DAVIS"

3 (b) If veteran, name war: ********

3 (c) Social Security Account No.:

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) 9 / 30/1880

8. AGE: Years 66 | Months 7 10 | Days 19 | If less than one day: ********** hr. min.

9. Birthplace: Baltimore Maryland (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: At Home

FATHER

12. Name: Henry Traupe

13. Birthplace: Germany

MOTHER

14. Maiden Name: Unknown

15. Birthplace: Germany

16 (a) Informant: Mrs. Edith E. Gorrick

(b) Address: 813 Unetta Ave. 29

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 21 Aug. 47 (month) (day) (year)

(c) Cemetery or crematory: Loudon Park Cemetery

Location: Baltimore Maryland

18 (a) Funeral director: F.B. WIPPERT & SON

(b) Address: 1300 Eutaw Place..17

19 AUG 21 1947 (b) Huntington Williams M.D.

(Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19 1947, at 1.35 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 9 1947 to August 19 1947, and that I last saw her alive on Aug 19 1947

	Duration
Immediate cause of death: Carcinoma of Stomach with metastasis	?
Due to:	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation 8-15-47

Major findings of operation: alone

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury:

23. Signature Charles R. MacDonald M. D.

Address 1213 Light St Date signed 7-19-47

VS 150

G54481

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G54481

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1621 E. 25th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles W. Burkhardt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Catherine L. Burkhardt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 7th, 1891

8. AGE: Years	Months	Days	If less than one day
56		13	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business R.W. Norris

FATHER
12. Name C.E. Burkhardt
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Minna Fischer
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. C.W. Burkhardt
(b) Address 1621 E. 25th St.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 8/23/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director Lasasha Funeral Home
(b) Address 7401 Belair Rd.

19 (a) Filed in registrar's office AUG 21 1947 (b) Signature Huntington Williams, M.D.

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 August 1947, at 3:30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Vascular Accident

Due to Arteriosclerotic Hypertension Vascular Disease.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer, Jr. M.D. Medical Examiner.
Date signed 20 August, 1947

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54482 BC# G 86826 **BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH** 160a Registered No. G54482

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address West. Balto General Hospital
(c) Hospital or institution: W.B.G.H. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto 16 - Md (If outside city or town limits, write RURAL and give town) 7
(d) Street No. 2820 Ellicott Drive (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Dollinger ~~Girl~~ KENNETH M. DOLLINGER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-20-47

8. AGE: Years	Months	Days	If less than one day
			6 hr. min.

9. Birthplace West Balto General Hospital (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Kenneth John Dollinger
13. Birthplace Balto Md.

MOTHER 14. Maiden Name Celtona Yanculavage
15. Birthplace Pa

16 (a) Informant Kenneth John Dollinger
(b) Address 2820 Ellicott Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 22 - 1947 (month) (day) (year)
(c) Cemetery or crematory Loraine Park
Location Woodlawn Md

18 (a) Funeral director Balto B. M. Walter Co
(b) Address Pratt & Stricker Sts

19 (a) AUG 21 1947 Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-20 1947, at 7:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-20 1947, to 8-20 1947, and that I last saw him alive on 8-20 1947.

Immediate cause of death Intracranial Hemorrhage — Duration
Due to unknown
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William Wylie Brittain M. D.
Address W. B. G. H. Date signed 8-21-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54483

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1475

G54483 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 325 S. Durham st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 - 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 325 S. Durham st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John M. Ratajczak
3 (b) If veteran, name war
3 (c) Social Security Account No. 215-09-4867

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Antoinette
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 30 1906
8. AGE: Years 41 | Months - | Days 21 | Under 1 day ... hr. ... min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business Bethlehem Steel Key Highway

FATHER
12. Name Michael Ratajczak
13. Birthplace Poland

MOTHER
14. Maiden Name Walentyna
15. Birthplace Poland

16 (a) Informant Mrs Antoinette Ratajczak
(b) Address 325 S. Durham st
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-23-47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County
18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street
19 (a) AUG 21 1947 (Date filed by Registrar) Huntington Williams M.D. Address Patterson Park Date signed 8-21-47

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 20 1947 at 6 10 A.M
21. I certify that death occurred on the date above stated; that I attended deceased from June 12 1947, to Aug 20 1947, and that I last saw him alive on Aug 19 1947.

Immediate cause of death: Myocardial Degeneration — Hypertension — Uremia — Chronic Nephritis

Duration: 1yr. / 4 mos / 4 " / over

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Geo D Lipsitz M. D.

G54484

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G54484 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 408 Kensington Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 4
(e) Length of stay in Baltimore (yrs., mos., or days) 60 4 10

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 408 Kensington Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Ella KeeFer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W.	widowed

6 (b) Name of husband or wife David B. Keefer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7, 1861

8. AGE: Years	Months	Days	If less than one day
86	1	13/14	hr. min.

9. Birthplace Somerset Co. Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Isaac Bosman
13. Birthplace Md

MOTHER
14. Maiden Name Jane Brewington
15. Birthplace Md.

16 (a) Informant Clarence E. Keefer
(b) Address 408 Kensington Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 23-1947 (month) (day) (year)
(c) Cemetery or crematory Blue Ridge
Location Thurmont, Md.

18 (a) Funeral director Mr. & Mrs. John R. Gentleson
(b) Address 5311 Edmondson Ave.

19 (a) AUG 21 1947 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 August 1947 at 2 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 17 Aug 1947 to 21 Aug 1947 and that I last saw h-- alive on 20 Aug 1947.

Immediate cause of death Sarcoma of Antrum - secondary
Due to Cardiac - Juvenile Diabetes

Duration

Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Carl B. Keefer M.D.
Address 142 Westerna Rd. Date signed 21 Aug 47

G54485

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1477

G54485 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5307 FERNPARK AVE.
(c) Hospital or institution:
28-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3044

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5302 Fernpark Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William L Kuhnle

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-05-0367

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Bertha M. Kuhnle

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Sept 26, 1890

8. AGE: Years 56 | Months 10 | Days 25 | If less than one day hr. min.

9. Birthplace Westernport Md (Town, county, and state)

10. Usual Occupation Accountant

11. Industry or business Stein Bros & Boyce

FATHER 12. Name Joseph Kuhnle

13. Birthplace Md

MOTHER 14. Maiden Name Annie Murphy

15. Birthplace Md

16 (a) Informant Bertha M. Kuhnle

(b) Address 5307 Fernpark Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 27 1947 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location City

18 (a) Funeral director Mr. & Mrs. John W. Teufel & Son

(b) Address 5311 Edmondson Ave

19 (a) AUG 21 1947 (Date received by Registrar) Huntington Williamsport, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20 1947, at 3 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1947 to Aug 20 1947, and that I last saw him alive on Aug 19 1947.

Immediate cause of death	Duration
Carcinoma of Lungs	6 MOS
Due to	
Due to	
Other Conditions with metastasis	2 MOS

(Include pregnancy within 3 months of death)

Date of operation Biopsy

Major findings of operation: CARCINOMA

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. T. Pisansky

Address 3210 Liberty Hgts Ave. Date signed Aug 20

Pearl Gibbons

BALTIMORE CITY HEALTH DEPARTMENT

G54486 **CERTIFICATE OF DEATH** √13/a Registered G54486

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1714 McCulloh
(c) Hospital or institution:
14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1714 McCulloh St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl Gibbons

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	N	Married

6 (b) Name of husband or wife Nathaniel Gibbons
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-15-97

8. AGE: Years	Months	Days	If less than one day
50	2	4	hr. min.

9. Birthplace Baltimore Md
(Town, county and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Charles H. Smith
13. Birthplace A.A. Co. Md

MOTHER
14. Maiden Name Sophie Robinson
15. Birthplace Bourbon Co. Va

16 (a) Informant Miss Elizabeth Gibbons
(b) Address 1714 McCulloh St

17 (a) Burial (b) Date thereof Aug. 24, 19
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Meth. Pk
Location Balto. Co. Md

18 (a) Funeral director Chas. Leo H. Holland
(b) Address 1631 Druid Hill Ave

19 AUG 21 1947 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/19 1947 at 10:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/9 1947 to 8/19 1947 and that I last saw h[illegible] alive on 8/19 1947.

Immediate cause of death	Duration
Uremia	
Due to Hypertension & Renal Disease	2-3 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Benton Evans, M.D.
Address 1514 Division St Date signed 8/20/47
M. D.

G54487

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 186a

Registered No. G54487

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2-
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL or give town)
(d) Street No. 116 S. Caroline St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JEFF DAVIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace Unknown (Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business

FATHER
12. Name unknown
13. Birthplace " "

MOTHER
14. Maiden Name unknown
15. Birthplace " "

16 (a) Informant Henrietta McCready
(b) Address 508 N. Duncan St.

17 (a) Burial (b) Date thereof Aug 21-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location Brooklyn Md

18 (a) Funeral director Elroy D. Wilson
(b) Address 1000 Hamilton Ave

19 (a) Date received by Local Registrar AUG 21 1947 (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/16 1947, at 5.25 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull
Intracranial hemorrhage
Due to Contusion of brain

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 3/1
(a) Date of injury 8-16-47 at 5 A. M.
(b) Where did injury occur? 116 S. Caroline St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Rolled off roof.

23. Signature George H. Merrill M.D.
Medical Examiner.
Date signed 8/16/47

G54188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1123

Registered No. G54188

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: So. Balto. Gen. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1645 E 25th St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Schultz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Helen E. Schultz

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) April 1, 1897

8. AGE: Years 50 | Months 4 | Days 18 | If less than one day: hr. min.

9. Birthplace: Balto., Md (Town, county, and state)

10. Usual Occupation: Ins. Underwriter

11. Industry or business

FATHER
12. Name: Fredk. S. Schultz
13. Birthplace: Germany

MOTHER
14. Maiden Name: Mary H. Slate
15. Birthplace: Maryland

16 (a) Informant: Wife
(b) Address: Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/47 (month) (day) (year)
(c) Cemetery or crematory: Baltimore
Location: Baltimore Md

18 (a) Funeral director: Ulman Funeral Home
(b) Address: 2004 Orleans St

19 (a) (Date rec'd by registrar) Huntington Williams M.D. Registrar

AUG 21 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-19- 1947, at 3:47 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-14- 1947, to 8-19- 1947, and that I last saw h[illegible] alive on 8-19- 1947

Immediate cause of death: Gangrene of the pneumonia — Duration: 2 days

Due to: Mesenteric thrombosis — 5 days

Due to: Coronary thrombosis — 2 wks

Other Conditions: Coronary atherosclerosis ?

(Include pregnancy within 3 months of death)

Date of operation 8-14-47

Major findings of operation: Mesenteric thrombosis

of autopsy: Gangrene of pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: [signature] M.D.
Address 121 Eager St Date signed 8/19/47

G54489

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G54489

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital 12-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 138 days
(e) Length of stay in Baltimore (yrs., mos., or days) 138 days

2. USUAL RESIDENCE OF DECEASED: NONE
(a) State ..... (b) County .....
(c) City or town ..... (If outside city or town limits, write RURAL and give town)
(d) Street No. ..... (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country .....

3 (a) FULL NAME DeShong, Theodore

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Wid.

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Apr. 22, 1867

8. AGE: Years	Months	Days	If less than one day
80	3	28 27	hr. ..... min.

9. Birthplace Lancaster, Pa. (Town, county, and state)
10. Usual Occupation Retired -CG
11. Industry or business Lighthouse Service

FATHER
12. Name Robert DeShong
13. Birthplace Pa.

MOTHER
14. Maiden Name Selina Ferguson
15. Birthplace Pa.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (b) Date thereof Aug 22-47 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Govans Presbyterian
Location Balto Md
18 (a) Funeral director Ellsworth Chapel
(b) Address 3911 Silverton Weights Ave
19 (a) AUG 21 1947 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19 1947, at 2:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 3 1947 to Aug. 19 1947, and that I last saw him alive on Aug. 19 1947.

Immediate cause of death	Duration
Arteriolar nephrosclerosis	?
Due to Hypertensive cardiovascular disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature [illegible]
Address U.S. Marine Hosp. Balto. Md. Date signed 8/20/47 M.D.

G54490

BALTIMORE CITY HEALTH DEPARTMENT X 5-5E

CERTIFICATE OF DEATH

G54490 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Essex (If outside city or town limits, write RURAL and give town)
(d) Street No. 403 Oriole Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Paul White

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-3-82

8. AGE: Years	Months	Days	If less than one day
65	1	9	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name Asberry White
13. Birthplace Md.

MOTHER 14. Maiden Name Marxy Carey
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School AUG 20 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) (Date rec'd by Registrar) Huntington Williams, M.D.
AUG 21 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1947 at 8.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 6 1947 to Aug 12 1947 and that I last saw h[illegible] alive on Aug 12 1947

Immediate cause of death Lymphosarcoma — Duration 6 mos
Due to
Due to
Other Conditions Benign Prost Hypertrophy a.s.m. Pneumonia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas E Van Metre Jr M.D.
Address Johns Hopkins Hosp Date signed 8/13/47

X

G54491

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registration No. G54491

A56940 306 160a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Linebora (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Butter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/14/47

8. AGE: Years | Months | Days: 3 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Butler
13. Birthplace Tenn.

MOTHER
14. Maiden Name Carie Hughes
15. Birthplace Tenn.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Lo[illegible] Johns Hopkins Medical Schoo AUG 20 1947

18 (a) Funeral director
(b) Address Commissioner of Health

19 (a) AUG 21 1947 (Date rec'd by Registrar) Washington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug-17- 1947 at 3 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-14- 1947 to 8-17- 1947. and that I last saw h[illegible] alive on 8-17- 1947.

	Duration
Immediate cause of death: Prematurity	
Due to	
Due to	
Other Conditions: Intraparanial Hemorrhage (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address Johns Hopkins Date signed 8-18-47 M.D.

159

C54492

CWK-92354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C54492

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Years
(e) Length of stay in Baltimore (yrs., mos., or days) 37 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 604 N. Redwood Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul Breen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1-1864

8. AGE: Years	Months	Days	If less than one day
82	8	14	hr. min.

9. Birthplace New Jersey
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Abraham Breen
13. Birthplace Holland

MOTHER
14. Maiden Name Nellie Blickardt
15. Birthplace Holland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School AUG 21 1947

18 (a) Funeral director Commissioner of Health
(b) Address
(c) Date AUG 21 1947 (Date received by Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 1947, at 12:05M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 28 1945, to Aug. 15 1947, and that I last saw him alive on Aug. 15 1947

Immediate cause of death	Duration
Cerebrovascular Accident	4 yrs
Due to Hypertensive Arteriosclerotic Cardiovascular disease	7
Due to Generalized Arteriosclerosis	7
Other Conditions Arteriosclerotic gangrene, R. toe & foot	7

(Include pregnancy within 3 months of death)

Date of operation 3-12-45 & 3-27-45

Major findings of operation: Arteriosclerotic gangrene, right toe & foot

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Balt. City Hosps. Date signed 8-20-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G54493 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 936 N. Patterson Pk Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 936 N. Patterson Pk. (If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Mary M. Ruzek

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Charles Ruzek

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24 1872

8. AGE: Years 76 | Months 1 | Days 24 | If less than one day ... hr. ... min.

9. Birthplace Bohemia (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Centonin Ruzek

13. Birthplace Bohemia

MOTHER 14. Maiden Name Centonia Mort

15. Birthplace Bohemia

16 (a) Informant Frank Ruzek

(b) Address 936 N. Gallagher Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-12-47 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balto. Md.

18 (a) Funeral director Frank Leach & Son

(b) Address 900 N. Eutaw St.

19 (a) AUG 22 1947 (b) Huntington Mills Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19 1947, at 12 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 17 1947 to Aug 19 1947 and that I last saw h[illegible] alive on Aug 19 1947

Immediate cause of death: Cardio Vascular Hypertension — Duration 2 days

Due to: Intracerebral Hemorrhage

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

Duration

Doc

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence ... at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [signature] M. D.

Address 900 N. Eutaw St. Date signed Aug 20 1947

654194

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 654194

1321a

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Exact age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1020 E 36th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1020 E 36th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Walter Reynolds

3 (b) If veteran, name war
3 (c) Social Security Account No. NONE

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lillie M

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30 1875

8. AGE: Years 72 | Months 1 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore MD
(Town, county, and state)

10. Usual Occupation Mattress Inspector

11. Industry or business

FATHER
12. Name Thomas Reynolds
13. Birthplace Baltimore MD

MOTHER
14. Maiden Name Mary Wolschlager
15. Birthplace Sykesville MD

16 (a) Informant Mrs LeRoy Reynolds
(b) Address 6 E Rundel St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/47 (month) (day) (year)
(c) Cemetery or crematory Dawn Grove
Location Dawn Grove Md

18 (a) Funeral director Wilhom Colvin
(b) Address 1217 E Fayette St
(c) Date received by registrar AUG 22 1947 Huntingtown Williamsport, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 August 1947, at 4:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 18 Aug 1947 to 21 Aug 1947 and that I last saw him alive on 20 Aug 1947.

	Duration
Immediate cause of death: Acute Pulmonary Oedema	6 hrs.
Due to: Arterio sclerotic Cardio-Vascular Renal Disease with auricular fibrillation	12 yrs.
Due to:	
Other Conditions: Right Partial Hemiplegia (Include pregnancy within 3 months of death)	
Date of operation:	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. H. Kammer, Jr.
Address 501 S Kenwood Ave Date signed 21 Aug 47

G54495

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c

G54495 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St
(c) Hospital or institution:
Home for the Aged Room 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1058 Holbrook St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Brady

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	W.

6 (b) Name of husband or wife Katie Van Dyke
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1861

8. AGE: Years	Months	Days	If less than one day
86	0	30	hr. min.

9. Birthplace Calvert Co. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Basil Brady
13. Birthplace

MOTHER
14. Maiden Name Louisa Washington
15. Birthplace

16 (a) Informant Estelle Forbes 1st Pos
(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Catonsville Md

18 (a) Funeral director Williams & Jay
(b) Address 1214 Park Ave

19 AUG 22 1947 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 20 1947, at 10 [illegible] AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 18 1947, to Aug 21 1947 and that I last saw h[illegible] alive on Aug 20 - 1947.

Immediate cause of death	Duration
Edema Lungs	2 days
Due to Chronic Myocarditis	5 yrs
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M.D.
Address 1631 E North Av Date signed 8/20/47
M. D.

G54496

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G54496
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please correct age is especially important. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 W. Lexington Street
(c) Hospital or institution:
Aged Women's and Aged Men's Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3½ yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W. Lexington Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Sadie Shafer

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1872

8. AGE: Years	Months	Days	If less than one day
75	1	9	hr. min.

9. Birthplace Futgroy-Ontario, Canada
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Hamilton Walker
13. Birthplace

MOTHER
14. Maiden Name Anna Lesly
15. Birthplace

16 (a) Informant Aged Women and Aged Men Home
(b) Address 1400 W. Lexington Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

AUG 22 1947 (Date rec'd by Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21 1947, at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1947 to August 21 1947 and that I last saw h[illegible] alive on August 21 1947.

Immediate cause of death	Duration
Respiratory Failure	
Due to Cerebral Hemorrhage	
Due to Generalized Arteria-Sclerotic Cardio-Vascular Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maurice Edward Day M. D.
Address 4-E-33 N. St. Balto. Md. Date signed 8/22/47

X.

G54497

BALTIMORE CITY HEALTH DEPARTMENT

BC# D86555 CERTIFICATE OF DEATH 1602

G54497

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2025 W. Fayette St.

(c) Hospital or institution: Bon Secours Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8hrs.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2025 W. Fayette St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Baby Boy O'Connell

3 (b) If veteran, name war / 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/21/47

8. AGE: Years 0 | Months 0 | Days 0 | If less than one day 8 hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name W. Bartlett O'Connell

13. Birthplace Baltimore

MOTHER 14. Maiden Name Mary Virginia Griffith

15. Birthplace Baltimore

16 (a) Informant W. Bartlett O'Connell

(b) Address 2025 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/22/47 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore, Md

18 (a) Funeral director H. W. Meuerton

(b) Address 805 N. Calvert St.

(a) Signature of local registrar (b) Huntington Williams, M.D.

AUG 22 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21 1947, at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 21 1947 to Aug 21 1947, and that I last saw him alive on Aug 21 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Cerebral anoxia	
Due to prolonged labor & difficult delivery transverse	
Other Conditions cesar	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature William F. Lan M. D.

Address B. S. St. Date signed 8-21-47

X

G54498

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

58B

G54498 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5603 Grouse Ct.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hattie Wilson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-12-35

8. AGE: Years 11 | Months 9 | Days 8 | If less than one day hr. min.

9. Birthplace D. C. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Roland Wilson
13. Birthplace D. C.

MOTHER
14. Maiden Name Sallie Strong
15. Birthplace D. C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 8/25/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (c) Date received by local registrar AUG 22 1947 Washington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20 19 47 at 2:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 13 19 47 to Aug 20 19 47 and that I last saw h[illegible] alive on Aug 20 19 47.

Immediate cause of death ?PULMONARY EMBOLISM — Duration

Due to RHEUMATIC HEART DISEASE WITH

Due to RHEUMATIC VALVULAR DISEASE

Other Conditions AURICULAR FIBRILLATION

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William A Spencer MD M. D.
Address Johns Hopkins Hosp. Date signed 8/20/47

G54499

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V131a

G54499 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga St.
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) one 48
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4812 Edmondson Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ROSE E King

3 (b) If veteran, name war ?

3 (c) Social Security Account No.

4. Sex F | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife ~~George~~ King

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1873

8. AGE: Years 73 | Months 7 | Days 27 | If less than one day hr. min.

9. Birthplace Maryland. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Lawrence Le Gourd
13. Birthplace Maryland, Balto.

MOTHER
14. Maiden Name Sarah C Small
15. Birthplace Maryland, Frederick Co.

16 (a) Informant Catherine King
(b) Address 4812 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 23, 1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location Baltimore, Md.

18 (a) Funeral director Wells Lamorgan
(b) Address 1510 Liberty Heights Ave.

(a) Date received by registrar AUG 22 1947 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 20 1947, at 6 55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 20 1947 to Aug 20 1947, and that I last saw h~~e~~r alive on Aug 20, 1947

Immediate cause of death: Cerebral Thrombosis — Duration: One week
Chronic Myocarditis — Several yrs.
Due to: Generalized arteriosclerosis — Several yrs.
C V R. disease.
Due to: — one day
Other Conditions: Embolism of left femoral artery
Coronary thrombosis
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Li Pira M. D.
Address Mercy Hosp Date signed 8-20-47

G54500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G54500

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2015 N. CALVERT ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 4210 CLARKDALE RD (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME IDA McDORMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	WIDOWED

6 (b) Name of husband or wife FRANCIS J.
6 (c) If alive, give age 0 years

7. Birth date of deceased (mo., day, yr.) MAY 20, 1857

8. AGE: Years	Months	Days	If less than one day
90	3	1	hr. min.

9. Birthplace DORCHESTER Co. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name MARSHALL
13. Birthplace DORCHESTER Co.

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace DORCHESTER Co.

16 (a) Informant MR. E RIGBY McDORMAN
(b) Address 2015 N. CALVERT ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8 | 23 | 47 (month) (day) (year)
(c) Cemetery or crematory LORRAINE.
Location WOODLAWN MD

18 (a) Funeral director JOHN F. DENNY INC.
(b) Address 715 LIGHT ST

AUG 22 1947 (Date rec'd by Registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG 21, 1947, at 6.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1947, to Aug 21 1947, and that I last saw h[illegible] alive on Aug 18 1947.

Immediate cause of death Coronary Thrombosis — Duration Aug 21/47
Due to arterio sclerosis —
Due to —
Other Conditions Arterial hypertension —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury —

23. Signature Louis J. Frommeyer M. D.
Address 722 N. Kenwood Ave Date signed Aug 21/47

AUG 22 1947

G54501

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G54501
Registered No.

BC# 186852 C ✓ 161a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1011 Leadenhall St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1011 Leadenhall St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Harry James Morand

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 19, 1947

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business —

FATHER — 12. Name	Hezekiah Morand
FATHER — 13. Birthplace	Chester, South Carolina
MOTHER — 14. Maiden Name	Athelia Kinlaw
MOTHER — 15. Birthplace	Manning, South Carolina
16 (a) Informant	Alethia Morand
(b) Address	1011 Leadenhall St.
17 (a) Burial (Burial, cremation, or removal)	(b) Date thereof 8-22-47 (month) (day) (year)
(c) Cemetery or crematory	Mt Calvary
Location	Balto Co Md
18 (a) Funeral director	Isaiah L. Brownstein
(b) Address	108 W Montgomery St
19 (Signature of local registrar)	Huntington Williams, M.D.

AUG 22 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 19 1947 to Aug 21 1947 and that I last saw him alive on Aug 21 1947

Immediate cause of death Atelectasis, bilateral, severe — Duration

Due to Insufficient filling of lungs at birth

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. W. Mayhew M.D.
Address Union Hosp Date signed Aug 22 47

M. D.

G54502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registration No. G54502

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2917 The Alameda
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2917 The Alameda
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph F. Fowders (Fowders)

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Theresa B. Fowders
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 8, 1879

8. AGE: Years	Months	Days	If less than one day
68	3	12	hr. min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation Retired Baker
11. Industry or business

FATHER
12. Name Vincent Fowders
13. Birthplace Austria

MOTHER
14. Maiden Name Anna Schaffer
15. Birthplace Austria

16 (a) Informant Mrs. Frances Boland
(b) Address 2917 The Alameda

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-23-1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Elmer F. Conklin & Son
(b) Address 924 E. Eager St.

19 AUG 22 1947 (b) Huntington Williams, M.D. Address Medical Arts Bldg. Date signed 8/20/47

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 20, 1947, at 2 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 3 1942 to Aug. 19 1947 and that I last saw him alive on Aug. 19, 1947.

Immediate cause of death	Duration
Arteriosclerotic cardio-vascular disease	5 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. A. Summitt M.D.

VS 150

G54503

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947 B

Registered No. G54503

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St
(c) Hospital or institution: Home for the Aged Room 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jennie Carberry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W.

6 (b) Name of husband or wife Chas. Carberry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 30, 1864

8. AGE: Years	Months	Days	If less than one day
82	9	21	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Hewston
13. Birthplace

MOTHER
14. Maiden Name Mary Hall
15. Birthplace

16 (a) Informant Estelle Carberry Hall Daughter
(b) Address 1200 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 23 1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Reja Sindfield
(b) Address 900 East Fredrick St

AUG 22 1947 (b) (Date received by Registrar) Registrar Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 20th 1947, at 4:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1- 1947, to Aug 20 1947, and that I last saw her alive on Aug 20-1947.

Immediate cause of death: Edema Lungs — Duration: 3 days

Due to: Mitral Stenosis — 8 yrs

Due to:

Other Conditions: Arterio-Sclerosis — 10 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Gill Hall M. D.

Address 1631 E. Northern Date signed 8/22/47

G54504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 M

G54504 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Greenspring Ave
(c) Hospital or institution: Aged Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Levendale (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Fishbein

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Rosie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 52 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Irvin
13. Birthplace Russia

MOTHER
14. Maiden Name Gertrude
15. Birthplace Russia

16 (a) Informant Irvin Fishbein
(b) Address 3000 Lesterstown Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-22-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) AUG 22 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21 1947, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-2 1947 to 8-21 1947 and that I last saw h[im] alive on 8-21 1947.

Immediate cause of death: Carcinoma of pelvis — Duration: 1942

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H Edmund Levin M.D.

Address Levendale Date signed 8/21/47

G54505 Dl# 5-85287

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 157E

G54505
Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Broadway
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 831 W 36 St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Hoffman

3 (b) If veteran, name war / 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-14-47

8. AGE: Years	Months	Days	If less than one day
		8	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Emanuel Hoffman
13. Birthplace Baltimore

MOTHER
14. Maiden Name Ethel Lubkin
15. Birthplace Balto

16 (a) Informant Emanuel Hoffman
(b) Address 831 W. 36th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 22-47 (month) (day) (year)
(c) Cemetery or crematory Woodmere Cemetery
Location Germon Hill Rd.
18 (a) Funeral director Jack Lewis Inc
(b) Address 2160 Eutaw Place
AUG 22 1947 (b) Huntington Williams Mort
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22, 1947, at 6 55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 9, 1947, to Aug 22 1947, and that I last saw h IM alive on Aug. 22, 1947.

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to Pulmonary Abscess, multiple	
Due to Aspiration	
Other Conditions Congenital Heart Dis.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: see above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Stanley H. Steinberg M.D.
Address Sinai Hospital Date signed 8/22/47

G54506

G54506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1832

Registered No. 5127

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution:
South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (30)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3703 S. Hanover St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles M. Powley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. ?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9, 1873

8. AGE: Years	Months	Days	If less than one day
74	4	9	hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business

FATHER
12. Name Michael Powley
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant George T. Conner (friend)
(b) Address 3703 S. Hanover St.

17 (a) Removal (b) Date thereof Aug 22-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Scottdale Pa.
Location Pennsylvania

18 (a) Funeral director Wilkinson-Lamb Inc
(b) Address 1211 St Paul St

AUG 22 1947 Huntington Williams Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/18 1947 at 12:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/14 1947 to 8/18 1947, and that I last saw h[illegible] alive on 8/18 1947.

Immediate cause of death cerebro-vascular accident — Duration

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature H. D. Cooper
Address Same Balti. Md. Date signed 8/20/47

VS 150

G54507

Spec.—4-9-19—H. P. Co.—1000 Bks.

G54507

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

95c

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 632 Laurens St ST.; WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Robinson

(a) RESIDENCE. No. 632 Laurens St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	?

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER unobtainable

11 BIRTHPLACE OF FATHER (city or town) 0
(State or country)

12 MAIDEN NAME OF MOTHER 0

13 BIRTHPLACE OF MOTHER (city or town) 0
(State or country)

14 Informant Annie Murphy
(Address)

AUG 22 1947 Leopold Williams Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-20-47

17 I HEREBY CERTIFY, That I attended deceased from 5-31-47, 19..., to 8-20-47, 19...,

that I last saw h... alive on 8-19-47, 19...,

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Chron. Cardiac Disease

(duration) yrs. mos 18 days

CONTRIBUTORY (Secondary) Apoplexy

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. M. Condon, M. D.

, 19 (Address) 524 Druid Hill Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Nat	8/25 1947
20 UNDERTAKER Geo. H. Kelson	ADDRESS 1303 Pennsylvania Ave

THIS IS TO BE CAREFULLY FILLED OUT BY PHYSICIANS. WRITE PLAINLY, WITH INK. CAUSE OF DEATH, AGE and OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

G54508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G54508 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 411 S. BOULDIN ST.

(c) Hospital or institution — NONE —

(d) Length of stay in hospital or inst. (yrs., mos., or days) —

(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:

(a) State MD. (b) County —

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 411 S. BOULDIN ST. (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country —

3 (a) **FULL NAME** GEORGE C. VASOLD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	MARRIED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-24-1886

8. AGE: Years	Months	Days	If less than one day
60	7	9	2H hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation IRON WORKER

11. Industry or business IRON

FATHER 12. Name MARTIN VASOLD

13. Birthplace BAVARIA

MOTHER 14. Maiden Name VERONICA WINTERLING

15. Birthplace GERMANY

16 (a) Informant PAULINE VASOLD - WIFE

(b) Address 411 S. BOULDIN ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-24-47 (month) (day) (year)

(c) Cemetery or crematory SACRED HEART CEM

Location GERMAN HILL ROAD

18 (a) Funeral director LILLY & ZEILER INC.

(b) Address 407 S. WOLFE ST.

19 AUG 22 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 21 1947, at 8:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-24-1945 to 8-21-1947. and that I last saw him alive on 8-21 1947.

	Duration
Immediate cause of death: Cerebral Hemorrhage	8 hrs
Due to: Cerebral arterio sclerosis	2 yrs +
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature N. J. Davitt M.D.

Address 3218 Eastern Ave Date signed 8-22-47

X

Dayton Balliet

G54509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

Registered No. G54509

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Fayette & Calhoun Sts.

(c) Hospital or institution Franklin Square Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balto

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 108 Riverside Rd. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Balliet Dayton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Victoria Balliet

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-12-13

8. AGE: Years 34 | Months 2 | Days 9 | If less than one day hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER 12. Name Charles Balliet

FATHER 13. Birthplace Pa.

MOTHER 14. Maiden Name Stella Stein

MOTHER 15. Birthplace Pa

16 (a) Informant Wife. Victoria Balliet

(b) Address 104 Riverside Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 25-47 (month) (day) (year)

(c) Cemetery or crematory Stairville Cem.

Location Pa.

18 (a) Funeral director Milton Schilling

(b) Address 3914 Hanover St

AUG 22 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 Aug 1947, at 6:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9 Aug 1947 to 21 Aug 1947, and that I last saw h. alive on 9 Aug 1947.

Immediate cause of death: Thrombosis of Rt Renal Vein — Duration: 12 days

Due to: Hemorrhagic Peptic Ulcer

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Thrombosis Rt Renal Vein Secondary to ulcer

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Maynard R Ramsey M. D.

Address Franklin Sq Hosp Date signed 21 Aug 47

G54510

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1947

Registered No. G54510

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto Gen Hosp 2nd floor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Wks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1032 Light St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Sigafoose

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife James

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1872

8. AGE: Years	Months	Days	If less than one day
75	6	29	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Baker
13. Birthplace Germany

MOTHER
14. Maiden Name Adelaide Ripson
15. Birthplace Md.

16 (a) Informant Family
(b) Address 101 First Ave. Bklyn.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/25/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Rd.

18 (a) Funeral director James L. McCauley
(b) Address 130 E. Fort Ave.
(Date rec'd by registrar) AUG 22 1947 (Registrar) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21 1947, at 12 40 AM

21. I certify that I took charge of the remains described above, held an Inq Exchange thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Helbrich M.D.
Medical Examiner.
Date signed Aug 22 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54511

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G54511 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address WILKENS & CATON AVE
(c) Hospital or institution: St Agnes' Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (11)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 409 Wyomann Park Apts city 11
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AMOS EUGENE BROWN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 30, 1899

8. AGE: Years	Months	Days	If less than one day
48	3	20	hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation Sculptor

11. Industry or business Custom Iron & Steel

FATHER 12. Name Alonzo Brown

13. Birthplace N.Y.

MOTHER 14. Maiden Name DORA

15. Birthplace N.Y.

16 (a) Informant Catherine Mary DeLaney

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 23/47 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Baltimore

18 (a) Funeral director Leonard J. Rust

(b) Address 5305 Hereford Rd

19 AUG 22 1947 (Date received by Local Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20 1947, at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 17 1947, to Aug 20 1947, and that I last saw h alive on Aug 20 1947.

Immediate cause of death: Myocarditis — Duration: 2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John D Burket, M.D.

Address 503 Oakleigh Rd Date signed 8-20-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 89a

Registered No. G54512

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: [illegible]
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6401 Harford Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Wallmere.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-16-92

8. AGE: Years 54 | Months 8 | Days 5 | If less than one day ____hr. ____min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation meat cutter

11. Industry or business

FATHER
12. Name Robert Wallmere
13. Birthplace Germany

MOTHER
14. Maiden Name Irene Bollam
15. Birthplace N. C

16 (a) Informant Mrs Louise Hattier
(b) Address 6401 Harford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 25, 47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore Md

18 (a) Funeral director Leonard Kuck
(b) Address 5305 Harford Rd

19 (a) AUG 22 1947 Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug- 21 1947, at 6 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug- 19 1947, to Aug- 21 1947, and that I last saw him alive on Aug- 21 1947.

	Duration
Immediate cause of death: Brain abscess	5-10 days
Due to: Chronic mastoiditis	20 yrs.
+ otitis media	
Due to	
Other Conditions: None	

(Include pregnancy within 3 months of death)

Date of operation Aug 20, 1947

Major findings of operation: Exposed brain abscess left cerebellar hemisphere

of autopsy: Yes showing above

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George G. Cullorth M. D.

Address Johns Hopkins Hospital Date signed Aug 2, 1947

PHYSICIAN

Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G54513 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2116 Mount Royal Terr. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AGNES ELIASON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife Edward R
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6, 1890

8. AGE: Years 57 | Months 5 | Days 14 | If less than one day hr. min.

9. Birthplace Balto MD (Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

MOTHER / FATHER
12. Name ?
13. Birthplace
14. Maiden Name ?
15. Birthplace

16 (a) Informant Mrs Howard League
(b) Address 8034 Pinewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 23 47 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore Md

18 (a) Funeral director Leonard Hirsch
(b) Address 5305 Harford Rd

19 (a) AUG 22 1947 (Date received by Registrar) (b) H. Covington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20 1947, at 1155P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/16 1947 to 8/20 1947, and that I last saw her alive on 8/20 1947.

Immediate cause of death	Duration
Ventricular Fibrillation	
Due to Coronary Occlusion & Myocardial Infarction	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice A. Perillo MD
Address Sinai Hosp Date signed M. 8 D. 21 47

X

G54514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 47a

Registered No. G54514

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Md. 6-8
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3308 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Emily V. Kratz
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Late George C Kratz
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Sept 7 1859
8. AGE: Years 87 86 | Months 11 | Days 14 | If less than one day hr. min.
9. Birthplace: England (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name: Henry Caimel Caines
13. Birthplace: England

MOTHER
14. Maiden Name: Julia Jane Chick
15. Birthplace: England

16 (a) Informant: Harry C Kratz
(b) Address 3308 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 23 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick Ave
18 (a) Funeral director Harry H Wright
(b) Address 4106 Edmondson Ave
19 (a) AUG 22 1947 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21 1947, at 12:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 20 1947, to Aug 21 1947, and that I last saw h alive on Aug 20 1947.

Immediate cause of death	Duration
generalized debility	unknown
Due to Carcinoma of larynx	
+ pos metastases.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: none
of autopsy: permit refused

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Eugene A. Patonicllet M. D.
Address Maryland Gen Hosp. Date signed 8-21-47

VS 150

X

G54515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G54515

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Caroline St
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 4hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 86

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4025 Belwood Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Margaret Hoffstetter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/6/1860

8. AGE: Years	Months	Days	If less than one day
86	11	15	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Hoffstetter
13. Birthplace Germany

MOTHER
14. Maiden Name Christine Penta
15. Birthplace Germany

16 (a) Informant Mrs. Wm. Harley
(b) Address 4025 Belwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-23-47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore

18 (a) Funeral director George A Farley
(b) Address [illegible]

AUG 22 1947

19 (a) (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-21 1947, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-21 1947 to 8-21 1947 and that I last saw her alive on 8-21 1947.

Immediate cause of death	Duration
Cardio respiratory failure	
Due to Spontaneous subdrachnoid	
Due to hemorrhage arteriosclerotic	
Other Conditions C-V disease	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert E May M. D.
Address St. Joseph's Hosp Date signed 8-21-47

G54516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

Registered No. G54516

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4014 E. Lombard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4014 E Lombard St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Antonina Patte

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Giuseppe Patte

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 26 1867

8. AGE: Years 77 | Months 8 | Days 5 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Cosmo Salvatore
13. Birthplace Italy

MOTHER
14. Maiden Name Unk
15. Birthplace Italy

16 (a) Informant Mrs. Margaret Patte
(b) Address 4014 E Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 25-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Edmondson Ave.

18 (a) Funeral director Thos J Connelly
(b) Address 1417 E Eager St

AUG 22 1947 (Date rec'd by registrar)

(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21, 1947, at 10:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-19-47 19..., to 8-21-47 19..., and that I last saw h alive on 8-21-47 19...

Immediate cause of death	Duration
Arteriosclerotic Cardiovascular Disease	
Due to	
Due to	
Other Conditions Chronic Arthritis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis Costantini, M.D.

Address 284 Bowling St. Date signed 8-22-47

VS 150

X

G54517

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G54517

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 626 N. Decker Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 626 N. Decker Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EMANUEL VECERA, SR.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Hedvigka (nee Kosova)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25, 1882

8. AGE: Years	Months	Days	If less than one day
64	8	5	hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Sparrows Point

FATHER
12. Name Frank Vecera
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Julia Mares
15. Birthplace Czechoslovakia

16 (a) Informant Mrs. Hedvigka Vecera - wife
(b) Address 626 N. Decker Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/47 (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Horner's Lane, Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 AUG 23 1947 (Date rec'd by Reg.) (b) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 20 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/10 1947, to 8/20 1947, and that I last saw him alive on 8/20 1947.

Immediate cause of death Hypertensive Cardio Vascular Renal Disease — Duration 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph Pokorny M.D.
Address 220 E. Madison St Date signed 8/22/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. G54518

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard + Greene Sts
(c) Hospital or institution: University Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Winfield
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rural - Sykesville
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hattie Wolbert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~or wife~~ Chas. S. Wolbert deceased

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1882

8. AGE: Years 65 | Months 3 | Days 17 | If less than one day ... hr. ... min.

9. Birthplace Carroll Co. Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Sylvester Lewis
13. Birthplace Maryland

MOTHER
14. Maiden Name Rhoda Fleming
15. Birthplace Maryland

16 (a) Informant Geo. S. Wolbert
(b) Address Woodbine, Md.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 8-25-47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Marvan Chapel
Location Woodbine, Carroll Co. Md.

18 (a) Funeral director C. M. Waltz
(b) Address Winfield, Md.

AUG. 23 1947 (Registrar) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/22 1947 at 7:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/7 1947 to 8/22 1947, and that I last saw her alive on 8/22 1947

Immediate cause of death	Duration
Postoperative cardiac Failure	acute
Due to Probable Carcinoma of Large Bowel - Left Side	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 8/21

Major findings of operation: Umbilical hernia; Ulcerating fibromatous mass - intra-abdominal

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. J. Phillips M. D.
Address University Hospital Date signed 8/22/47

G54519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G54519

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 A
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1505 Patapsco Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Caldwell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1, 1898

8. AGE: Years	Months	Days	If less than one day
49	7	20	hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name William P Kinsley
13. Birthplace Balto

MOTHER
14. Maiden Name Della Sherlock
15. Birthplace Md

16 (a) Informant Parker L Kinsley
(b) Address 4506 Pinehurst Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Aug 25 1947 (month, day, year)
(c) Cemetery or crematory Leakin Park
Location Balto

18 (a) Funeral director A. Howard Evans
(b) Address 1420 N Charles St

AUG 23 1947 (Date rec'd by registrar) (Huntington Williams, M.D.) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21, 1947, at 9:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage

Hemorrhage, Subarachnoid

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Kaylor M.D.
Medical Examiner

Date signed 8-22-47

G54520

LW 112847

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓107

Registered No. G54520

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4207 Stanwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Daniel Webster Cox.

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-8981

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Margaret
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 21- ?

8. AGE: Years	Months	Days	If less than one day
69	-	1	hr. min.

9. Birthplace Ky.
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof aug 25-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore Md.

18 (a) Funeral director Jennie Cook Lefer
(b) Address 1600 W. North Ave.

19 (a) AUG 28 1947 (b) Huntington Williams, M.D.
(Local registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 22 1947, at 7:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-8- 1947 to 8-22 1947, and that I last saw h im alive on Aug. 22 1947.

Immediate cause of death	Duration
Bronchopneumonia	3-5 d.
Due to carcinoma organisms	
Due to	
Other Conditions Parkinsonism	

(Include pregnancy within 3 months of death)
Date of operation No Surgery
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold J. Nelson M.D.
Address BCH Date signed 8-26-47

X

G54521

AB-110524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/31a

Registered No. G54521

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 3mos.?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 115 N. Chapel St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Bradley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	Separated

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-?

8. AGE: Years	Months	Days	If less than one day
70?			hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof 8-23-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location Baltimore

18 (a) Funeral director Walter B. Spragg
(b) Address 1394 W. Hamburg St.

19 (a) 8/23/47 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION AM

20. DATE OF DEATH August 16 1947 at 6.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-8- 19 47 to 8-16 19 47 and that I last saw h im alive on 8-16 19 47

Immediate cause of death	Duration
Bronchopneumonia	
Due to Hypertensive & Arteriosclerotic C-V Disease	
Due to	
Other Conditions B.P.H., Nephrosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert A. Farber M. D.
Address Balto. City Hosp. Date signed 8-21-47

G54522

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G54522

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 718 W. Franklin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Sweeney

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife

6 (c) If alive, give age years

20. DATE OF DEATH August 20 1947, at 7 P. M.

7. Birth date of deceased (mo., day, yr.)

21. I certify that I took charge of the remains described above, held an Partial autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to h[illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

8. AGE: Years	Months	Days	If less than one day
25			hr. min.

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: John Sweeney
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Malinda
15. Birthplace: Virginia

16 (a) Informant: Nimon Johnson
(b) Address: 718 W. Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-23-47 (month) (day) (year)
(c) Cemetery or crematory: Halifax
Location: Virginia

18 (a) Funeral director: Adolphus Halstead
(b) Address: 918 Druid Hill Ave.

19 AUG 23 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Ryon M.D. Medical Examiner.
Date signed

VS 181

G54523 IBP 1st

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1-31a

G54523 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 222 Douglas Ct.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 222 Douglas Ct.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-6982

4. Sex M | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Bell Hopkins

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) 9-21-89

8. AGE: Years 57 | Months 11 | Days 0 | If less than one day hr. min.

9. Birthplace St. Michaels Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Unemployed

FATHER
12. Name James Wilson
13. Birthplace Eastern Shore, Md

MOTHER
14. Maiden Name Lucy Jones
15. Birthplace Balto. Md.

16 (a) Informant Millie Wright
(b) Address 205 Penna. Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-23-47 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location A.A. Co., Md.

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Ave.

19 AUG 22 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21, 1947 at 3:04 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1946 to Aug 21 1947, and that I last saw him alive on Aug 19 1947

Immediate cause of death Hemiplegia — —

Due to Hypertensive Cardiovascular renal disease — 1-2 yrs

Other Conditions Paraplegia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature G. C. Burrell M. D.
Address 121 Regnier Date signed 8-22-47

VS 150

X

G54524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G54524

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5229 Denmore Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMITT WILSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
60	8	4	hr. min.

9. Birthplace Portsmouth, Va.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Unemployed

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Mrs. Myrtle Brown
(b) Address 5229 Denmore Ave.

17 (a) Burial (b) Date thereof 8/25/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Balto. National
Location Fredrick Ave.

18 (a) Funeral director Charles R. Law
(b) Address 802 Mad. Ave.

19 (a) AUG 23 1947 (b) Huntington Williams M.D.
(Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21, 1947, at 11.25 A M

21. I certify that I took charge of the remains described above, held an insp. & inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Thos. A. Merrill M.D.
Medical Examiner.
Date signed 8-21-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54525

BALTIMORE CITY HEALTH DEPARTMENT

CWK-113127

CERTIFICATE OF DEATH 131a

Registered No. G54525

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Since Youth

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1261 Washington Boulevard
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dominick Corrieri

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife ? FLECIA Corriere

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 7-1867

8. AGE: Years	Months	Days	If less than one day
80	0	14	hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation Retired —

11. Industry or business Restaurant Owner

FATHER
12. Name Frank CORRIERI
13. Birthplace Italy

MOTHER
14. Maiden Name Angelina SEIRO
15. Birthplace Italy

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/25/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location

18 (a) Funeral director Charles J. Schwab
(b) Address 3512 Frederick Ave.

19 AUG 23 1947 (Date rec'd by registrar) (b) Huntington Williams

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH August 21 1947, at 11:15M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 18 1947, to Aug. 21 1947, and that I last saw him alive on Aug. 21 1947.

Immediate cause of death	Duration
? Uremia	
? Head injury	
Cardio - Vas. Hyper Renal Disease	
Due to HCVD. M.M.	
Due to	
Other Conditions ~~Heat Exhaustion~~	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert A. Farber M. D.
Address Balto City Hosp. Date signed 8-22-47

Harold J. Magelis, M.D.

over

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

654526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

137a

Registered No. 654526

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2513 CALVERT STREET.
(c) Hospital or institution:
NONE
(d) Length of stay in hospital or inst. (yrs., mos., or days) NONE
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town CITY OF BALTIMORE.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2513 CALVERT STREET.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES WEBER.

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Mary S. Weber
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 21, 1855

8. AGE: Years	Months	Days	If less than one day
92	6	1	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Christian Weber
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Albus
15. Birthplace Germany

16 (a) Informant Miss Bertha Winter
(b) Address 2513 N. Calvert St.

17 (a) Burial (b) Date thereof 8/25/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Pk. Cem.
Location Baltimore Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

19 AUG 23 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 22 1947 at 4. P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from JANY 8 1947 to AUG 22 1947 and that I last saw h IM alive on AUG 22 1947.

Immediate cause of death	Duration
CHRONIC MYOCARDITIS. JANY	8. 1947
Due to ARTERIOR SCLEROSIS.	1947.
Due to	
Other Conditions HYPERTROPHY OF PROSTATE (RETENTION)	AUG 12. 1947

(Include pregnancy within 3 months of death)

Date of operation NONE
Major findings of operation: NONE
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas. P. Winter M. D.
Address 3013 ST PAUL ST AUGUST 22, 1947. Date signed

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G54527

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V92E

Registered No. G54527

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5400 Tramore Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5400 Tramore Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME MARTHA BELL LUTZ

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband ~~or wife~~ Elisha Hanson Lutz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3, 1863

8. AGE: Years	Months	Days	If less than one day
84	2	18	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Home
11. Industry or business

FATHER
12. Name Samuel Roe
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Botterial
15. Birthplace Md.

16 (a) Informant Mrs. J. E. Gebhart, Daughter
(b) Address 5400 Tramore Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC
(b) Address North & Pa. Aves. Balto. 17, Md

19 (a) Aug 23 1947 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/21/47 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 27 1947 to Aug 21 1947, and that I last saw h[illegible] alive on Aug 20 1947.

Immediate cause of death	Duration
Myocardelesis	
Due to	
Due to	
Other Conditions Senility	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? None
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature John M Evans M. D.
Address 612 N 40 St. Date signed

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

CWK-T1848 C54528 — 13B — Registrar's No. C54528

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 163
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 36 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 714 N. Vincent Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie Liston

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife James (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3-1899

8. AGE: Years	Months	Days	If less than one day
48	5	15	hr. min.

9. Birthplace North Carolina
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Williams
13. Birthplace North Carolina

MOTHER
14. Maiden Name Matilda Bellamy
15. Birthplace North Carolina

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Interred (b) Date thereof 8/23/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Warren, D. C.
18 (a) Funeral director William A. Jackson
(b) Address 916 Penna. Ave
19 AUG 21 1947 Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH August 18 1947, at 10:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 8 1947 to Aug. 18 1947, and that I last saw her alive on Aug. 18 1947.

Immediate cause of death	Duration
Respiratory failure	3 da
Due to Tuberculosis of lungs	3 mo
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Joseph Brown Jr M. D.
Address Balto City Hosp Date signed 8-1 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G54529 Registered No.

1576

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor and Dukeland
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Street
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Jane Sturgis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 24 Feb 1947

8. AGE: Years	Months	Days	If less than one day
0	5	29	hr. min.

9. Birthplace Havre De Grace, Md.
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business —

FATHER
12. Name Woodrow W. Sturgis
13. Birthplace Va

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Father
(b) Address Street, Md.

17 (a) Burial (b) Date thereof Aug 25, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Darlington
Location Harford Co. Md.

18 (a) Funeral directors H. L. Bailey
(b) Address Darlington Md.

19 (a) Filed [illegible] (b) Registrar

8-21-1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 Aug 1947, at 3:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12 Aug 1947 to 23 Aug 1947 and that I last saw her alive on 23 Aug 1947

Immediate cause of death: Status Epilepticus (Cause not determined) — Duration: 1 day

Due to

Due to

Other Conditions: Spina Bifida with Menigocele — Since Birth
(Include pregnancy within 3 months of death)

Date of operation 20 Aug 47

Major findings of operation: Menigocele - Spina Bifida

of autopsy: Not Done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. W. Bell M.D.
Address West Baltimore General Hospital Date signed 23 Aug 47

X

G54530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G54530 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 1400 N. CAROLINE ST.
(c) Hospital or institution: ST. JOSEPH'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 12 DAYS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Harford
(c) City or town RURAL-PYLESVILLE, MD
(If outside city or town limits, write RURAL and give town)
(d) Street No. PYLESVILLE, MD (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MARY McELWAIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife WINFIELD McELWAIN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/1/1887

8. AGE: Years	Months	Days	If less than one day
60	3	22	hr. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name Thomas Hanson
13. Birthplace Unknown

MOTHER
14. Maiden Name Matilda Brandell
15. Birthplace Unknown

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/26/47 (month) (day) (year)
(c) Cemetery or crematory Fair View
Location Fair View Pa

18 (a) Funeral director Howard Huff
(b) Address Fair View Pa

19 (a) 1947 (Date rec'd by registrar) Washington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/23/47 at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw her alive on 8/23 1947

Immediate cause of death RESPIRATORY FAILURE — Duration
Due to HYPOSTATIC BRONCHOPNEUMONIA
Due to CHRONIC MYOCARDITIS — 1 YR
Other Conditions SENILE DEMENTIA CEREBRAL ARTERIOSCLEROSIS
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Pulmonary edema Chronic passive congestion

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry J. Hanshaw M.D.
Address St. Joseph Hosp Date signed 8/29/47

G54531 (G54530)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

G54531 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) 55 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore Zone 18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 2436 No. Calvert St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Miss Helen Patterson Wroth

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 14, 1892

8. AGE: Years 55 | Months 6 | Days 8 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Stenographer

11. Industry or business

FATHER — 12. Name Henry A. Wroth
13. Birthplace Maryland.

MOTHER — 14. Maiden Name Isabel Hammell
15. Birthplace Maryland

16 (a) Informant Mr. Paul F. Wroth
(b) Address 2436 No Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/25/47 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore, Md.

18 (a) Funeral director H. W. Meaks and Son
(b) Address 805 N. Calvert St.

19 (a) [illegible] Washington Williams, Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22 1947, at 7:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 26 1947 to August 22 1947, and that I last saw her alive on August 22 1947.

	Duration
Immediate cause of death: Cardiac Failure	24 hours
Due to: Generalized Carcinomatosis	6 months
Due to: Carcinoma of Rectum	
Other Conditions: Arteriosclerotic heart disease; chronic cystic mastitis	

(Include pregnancy within 3 months of death)

Date of operation 6-27-46

Major findings of operation: Carcinoma of rectum

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. G. Chambers
Address Union Memorial Hospital Date signed 8/22/47 (M. D.)

X

G54532

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G54532 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home and Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) /
(e) Length of stay in Baltimore (~~yrs., mos.~~, or days) /

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Severna Park
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Boro

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mrs Fannie Boro
6 (c) If alive, give age 60 years
7. Birth date of deceased (mo., day, yr.): Unknown
8. AGE: Years: Approx 63 yrs | Months | Days | If less than one day: ..... hr. ..... min.
9. Birthplace: Russia (Town, county, and state)
10. Usual Occupation: Merchant
11. Industry or business

FATHER
12. Name: Louis Boro
13. Birthplace: Russia

MOTHER
14. Maiden Name: Rosie Boro
15. Birthplace: Russia

16 (a) Informant: Leon Boro (Son)
(b) Address: Severna Park Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-24-47 (month) (day) (year)
(c) Cemetery or crematory: Rosedale
Location: Phila Rd & Hamilton Ave

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 260 Eutaw Place

19 (a) Aug 24 1947 (Date received by registrar) (b) ..... Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 22 1947, at 9.40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 21 1947, to Aug 22 1947, and that I last saw h~~im~~ alive on 22 Aug 1947.

Immediate cause of death	Duration
Cardio - respiratory failure	
Due to Myocardial degeneration	6 mo.
Due to	
Other Conditions Dementia (not classified)	2 mo

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Richard M. Garrett M. D.
Address: Church Home & Hosp Date signed 22 Aug 47

X

Colter 11 E Chase 654533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 654533

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 611 Radnor Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 611 Radnor Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Belle Kimmeth

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife William L
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27-1877

8. AGE: Years	Months	Days	If less than one day
70	1	24	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles B. Gorman
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Anna Senft
15. Birthplace Baltimore Md

16 (a) Informant William L. Kimmeth
(b) Address 611 Radnor Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/25/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd

19 (a) Address of registrar (b) Clayton Williams, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 16 1947, to Aug 21 1947, and that I last saw h[illegible] alive on Aug 21 1947.

Immediate cause of death	Duration
Cerebral hemorrhage	6 days
Due to Hypertension	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward F. Colter M. D.
Address 11 E. Chase St. Date signed Aug 23, 1947

V S 150

G54534 BALTIMORE CITY HEALTH DEPARTMENT G54534
Registered No.

CERTIFICATE OF DEATH 44B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2908 Bayonne Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Frederick W. Letsch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-29-1868

8. AGE: Years 78 | Months 10 | Days 24 | If less than one day hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Retired merchant

11. Industry or business

FATHER 12. Name

13. Birthplace Unc

MOTHER 14. Maiden Name Augusta Olendorf

15. Birthplace Unc Germany

16 (a) Informant Mrs Margaret P. Letsch

(b) Address 2908 Bayonne Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-25-42 (month) (day) (year)

(c) Cemetery or crematory Schwartz Conn

Location Balto. Md

18 (a) Funeral director Leonard J. Rush

(b) Address 5305 Harford Rd

19 (a) (b) [illegible] Washington Williams Registrar

(Date rec'd by registrar) AUG 24 1942

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/22 1942 at 5:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/12 1942 to 8/22 1942, and that I last saw h. alive on 8/22 1942

Immediate cause of death Probable Hodgkin's Disease — Duration Unknown

Due to

Due to

Other Conditions Retroperitoneal Sarcoma Generalized. — Duration Unknown

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Retroperitoneal lymph node enlargement, generalized.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. S. Gallagher M. D.

Address University Hosp. Date signed 8/22/42

Dr 654535 ✓ 654535

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2820 Overland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County .....
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2820 Overland Ave
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Catherine Agnes Hoffman

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife John C.
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 3-1877

8. AGE: Years	Months	Days	If less than one day
69	10	18	..... hr. ..... min.

9. Birthplace Balto. Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas J. Byrnes
13. Birthplace Md

MOTHER
14. Maiden Name Ann Dempsey
15. Birthplace Md

16 (a) Informant John C. Hoffman
(b) Address 2820 Overland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/25/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location .....

18 (a) Funeral director Leonard J. Rusch
(b) Address 5305 Harford Rd.

19 (a) ..... (b) Signature of registrar Langston Williams, M.D.

AUG 24 1947

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-21- 19 47, at 7A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1935 19 .., to 8-21 1947 and that I last saw h alive on 8-21 19 47

Immediate cause of death	Duration
Bronchio Pneumonia	2 days
Due to Cerebral Hemorrhage	14 days
Due to Hypertension	7 Years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....
23. Signature C. W. Peake M. D.
Address 4504 Harford Rd Date signed 8-22-47

G54536 | BALTIMORE CITY HEALTH DEPARTMENT | G54536 Registered No.

CERTIFICATE OF DEATH 927

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1709 Valley St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1709 Valley (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary A St Leger

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: M.

6 (b) Name of husband or wife: Beatherance St Leger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1856

8. AGE: Years 90 | Months 9 | Days 11 | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Giblan
13. Birthplace Ireland

MOTHER
14. Maiden Name
15. Birthplace ?

16 (a) Informant Joseph St. Leger
(b) Address 1709 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 26 1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wisetzfield
(b) Address 900 E Biddle St

AUG 24 1947 Washington Williams, M.D. Registrar
(Date filed by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 22 1947, at 6A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 13 1947, to Aug 24 1947, and that I last saw h alive on Aug 24 1947.

Immediate cause of death	Duration
Chronic Myocarditis	
Due to Congestive Cardiac	
Due to failure	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature E J Kirby M. D.
Address 110 E North Ave Date signed 8/22/47

G54537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G54537 Registered No.

83a

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH: Ashburton Nursing Home

(a) Baltimore City, Maryland

(b) Street address 3520 Hilton Rd.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3520 Hilton st (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Ellen R. Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife John J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2 1885

8. AGE: Years 62 | Months 1 | Days 10 | If less than one day hr. min.

9. Birthplace Maryland (Town, county and state)

10. Usual Occupation Retired Nurse

11. Industry or business

FATHER 12. Name John Caldwell

13. Birthplace Md.

MOTHER 14. Maiden Name Mary Parkins

15. Birthplace Md.

16 (a) Informant Beulah Mae Messenger

(b) Address 3413 Edmondson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-25-47 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Frederick Ave

18 (a) Funeral director John R. Rea

(b) Address 5635 Ark.ton Ave, Bal.

19 (a) (Date filed by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/13 1944 to 2 23 1947, and that I last saw h alive on 2/23 1947.

Immediate cause of death a Paralysis of Hemiplegia

Due to b Embolism

Due to c High Blood Pressure & Heart Disease

Other Conditions Senility & Arteriosclerosis

Duration 2 yrs 1 mo

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature A. E. Hearn M.D.

Address 7901 Eastern Ave Balto 24 Md. (Signed)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Type correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G54538 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lowland + Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1300 St Paul
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Claiborne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Elizabeth L. Claiborne

6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Nov 30 1871

8. AGE: Years	Months	Days	If less than one day
75	8	24	hr. min.

9. Birthplace Richmond, Va
(Town, county, and state)

10. Usual Occupation Retired Merchant

11. Industry or business

FATHER
12. Name Felix G. Claiborne
13. Birthplace Richmond Va

MOTHER
14. Maiden Name Ella Palmer
15. Birthplace Richmond Va

16 (a) Informant Mrs. E. L. Claiborne
(b) Address 1300 St Paul

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-25-47 (month) (day) (year)
(c) Cemetery or crematory Rose Hill
Location Hagerstown, Md

18 (a) Funeral director C. M. Suter + Sons
(b) Address Hagerstown, Md.

19 (a) (Date received by central office) Huntington Williams, M.D.

AUG 24 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/24 1947, at 6:13 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/24 1947, to 8/24 1947, and that I last saw him alive on 8/24 1947

Immediate cause of death Acute Pulmonary Edema — Duration

Due to Myocardial Infarction — 3 wks
Acute Urinary Retention

Due to Prostatic Hypertrophy

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: I

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. S. Phillips M. D.
Address University Hosp Date signed 8/24/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54539 G71213 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 122B ✓ Registered No. G54539

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1323 N. Kenwood Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Baby Delfinie Zachmeier
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/16/47

8. AGE: Years	Months	Days	If less than one day
	6	6	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Mr. William Zachmeier
13. Birthplace Germany

MOTHER
14. Maiden Name Ella Buell
15. Birthplace Germany

16 (a) Informant William Zachmeier
(b) Address 1323 N. Kenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/25/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem. Location Belair Road
18 (a) Funeral director John C. Miller Inc.
(b) Address 2435 E. Oliver St.
19 AUG 25 1947 (Date received by registrar) Huntington Williams, M.D. (Address)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 1947, at 2:45 AM
21. I certify that death occurred on the date above stated; that I attended deceased ~~from~~ August 22 1947 to 19, and that I last saw h[illegible] alive on August 22 1947

Immediate cause of death	Duration
Post-operative shock	
Due to Pre-operative intestinal obstruction	
Due to Intussusception	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation August 23, 1947
Major findings of operation: Intussusception of ileum into caecum
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Paul D. Mannix M. D.
Address Bon Secours Hosp. Date signed 8/23/47

G54540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

837

Registered No. G54540

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Levindale Home
(c) Hospital or institution: Belvedere Ave & Greenspring Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophia Saxon

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Harry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Joseph Meerson
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant William Saxon
(b) Address Georgian Court Apt

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 25, 1947 (month) (day) (year)
(c) Cemetery or crematory Arlington Cemetery
Location Rogers Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) AUG 25 1947 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

28. DATE OF DEATH August 24 1947, at 5:2 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-31- 1944 to 8-24 1947, and that I last saw her alive on 8-24 1947

Immediate cause of death Hemiplegia
Hypertension — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Edmund Peery M. D.
Levindale Date signed 8/29/47

G54541

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G54541

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland West Baltimore General Hosp

(b) Street address Rayner Ave & Pukeland St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2776 W North Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WEINSTOCK (N) JULIUS

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-20-7736

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Jennie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 12, 1876

8. AGE: Years	Months	Days	If less than one day
71	-	12	hr. min.

9. Birthplace Austria
(Town, county, and state)

10. Usual Occupation

11. Industry or business Bakery

FATHER
12. Name Issac Weinstock
13. Birthplace Austria

MOTHER
14. Maiden Name Dora ?
15. Birthplace Austria

16 (a) Informant Samuel Weinstock
(b) Address 2776 W North Ave

17 (a) Burial (b) Date thereof Aug 25, 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Work Men Circle Cem
Location German Hill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) AUG 25 1947 Austin for Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 1947 at 9 AM

21. I certify that death occurred on the date above stated; that I attended deceased from August 24 1947 to August 24 1947 and that I last saw h[illegible] alive on August 24 1947

Immediate cause of death	Duration
(a) Pulmonary edema	
Due to (b) Arteriosclerotic - cardiac failure	
Due to (c) Hypertensive arterio-sclerotic cardiac disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Pulmonary Edema Hypertrophy of left ventricle

of autopsy: Arterio Sclerosis of aorta

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Leonard Teicher M. D.

Address West Baltimore Station Signed Aug 24, 47

G54542

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. G54542

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 66 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3545 Fifth St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Julius Crowl

3 (b) If veteran, name war	3 (c) Social Security Account No.
WW 2	217-12-7308

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3, 1924

8. AGE: Years	Months	Days	If less than one day
23	1	18	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business

FATHER
12. Name Louis Crowl
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Rose Gast
15. Birthplace Baltimore, Md.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8 25 47 (month) (day) (year)
(c) Cemetery or crematory CEDAR HILL
Location RITCHIE HWY.

18 (a) Funeral director JOHN F. DENNY, INC.
(b) Address 715 LIGHT ST.

19 (a) AUG 25 1947 (Date received by Registrar) Huntington Williams, M.D. (Signature of Registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21 1947, at 12:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1947 to Aug. 21 1947, and that I last saw him alive on Aug. 21 1947.

Immediate cause of death (1) Retroperitoneal mass involving retroperitoneal lymph nodes, both ureters with bilateral hydronephrosis & sigmoid colon.
Due to (2) Left lower lobe pneumonia with left hydrothorax
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert E. Miller M.D.
Address US Marine Hosp. Baltimore, Md. Date signed 8/21/47

X

G54543

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered G54543

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3500 Hamilton Avenue
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) -
(e) Length of stay in Baltimore (yrs., mos., or days) -

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3500 Hamilton Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jane Mary deGruchy Hine

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1857

8. AGE: Years	Months	Days	If less than one day
89	9	9	hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John de Gruchy
13. Birthplace England

MOTHER
14. Maiden Name Jane Valdy
15. Birthplace England

16 (a) Informant Mrs. Charles Howard
(b) Address 4308 Wendover Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 25-47 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Parkwood Cemetery
18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street
19 (a) AUG 25 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22 1947, at 12-03 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1947 to Aug 22 1947 and that I last saw her alive on Aug 20 1947

Immediate cause of death	Duration
Ch. Myocarditis	2 mo
Due to Senility	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: -
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Harding M. D.
Address 390 S. Belair Rd. Date signed Aug 27 47

G54544

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1947

Registered No. G54544

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1505 Lakeside Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1505 Lakeside Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John A. White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Widowed

6 (b) Name of husband or wife Amelia V.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 29, 1866

8. AGE: Years	Months	Days	If less than one day
81	3	23	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Retired - Cashier & Disbursing Officer
11. Industry or business

FATHER
12. Name Matthew White
13. Birthplace Ireland

MOTHER
14. Maiden Name Sarah Paterson
15. Birthplace Scotland

16 (a) Informant George M. White
(b) Address 110 Witherspoon Road

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 8/25/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) AUG 25 1947 (Date received) Huntington Wills (Registrar) M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22, 1947, at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1947, to Aug 22 1947, and that I last saw him alive on Aug 21 1947.

Immediate cause of death aplastic anemia — Duration 4-5 mos.
Due to cause unknown. —
Due to —
Other Conditions Retinosclerotic heart disease & arteriolar fibrosis. — 6-8 mos.
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: Gross - marrow aplasia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Harry F. Klemperer M.D.
Address 1101 St. Paul St. Date signed Aug. 23

C54545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √46E

Registered No. C54545

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard + Lidia Sts.
(c) Hospital or institution: Maryland General Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 47 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 515 E. 41st St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Novak.

3 (b) If veteran, name war –

3 (c) Social Security Account No. –

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Rev. Frank Novak
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13, 1880

8. AGE: Years 67 | Months 7 | Days 11 | If less than one day hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name ? Neubauer
13. Birthplace Austria

MOTHER
14. Maiden Name Unknown
15. Birthplace Austria

16 (a) Informant Johanna Swearer
(b) Address 515 E. 41st St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/29-47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location Baltimore

18 (a) Funeral director Wm. Cook Inc.
(b) Address 217 St Paul St

19 (a) AUG 25 1947 (Date rec'd by registrar) Washington Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 1947 12:41 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-8 1947 to 9-24 1947 and that I last saw h. alive on Aug 24 1947

Immediate cause of death general debility — Duration

Due to generalized carcinomatosis — months

Due to ca of stomach

Other Conditions –

(Include pregnancy within 3 months of death)

Date of operation July 8-1947

Major findings of operation: Ca of stomach + metastases

of autopsy: none granted

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E Patonblat M. D.
Address Md. Gen Hosp Date signed 8-28-47

X

G54546

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G54546

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution:
Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2024 N. Paul St
(If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country ?

3 (a) FULL NAME Mrs. Rosie Block

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife ? Harry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1, 1880

8. AGE: Years 67 | Months X 5 | Days X 13 | If less than one day 22 hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Mr Jacob Shea.
13. Birthplace Russia

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr David Block.
(b) Address 2024 N Paul St. Balto 18.

17 (a) Burial. (b) Date thereof 8-25-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Old Rd & Hamilton Ave

18 (a) Funeral director Jacob Lewis Inc
(b) Address 2400 Eutaw Place

19 (a) AUG 25 1947
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 23 1947 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 21 1947 to Aug 23 1947, and that I last saw h[illegible] alive on Aug 23 1947.

Immediate cause of death Cardiac decompensation. — Duration 5 days

Due to Arteriosclerotic heart disease — 20 yrs

Due to —

Other Conditions Arteriosclerosis generalized. One kidney.
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature David Bachrach M. D.
Address Church Home & Hosp Date signed 8/22/47

Huntington Williams, M.D.

X

G54547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G54547

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 years.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3817 Callaway Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Elsie Hankin Levin

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Isaac E. Levin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1903

8. AGE: Years	Months	Days	If less than one day
43	8	14	hr. min.

9. Birthplace Delaware (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Harry Hankin
13. Birthplace Europe

MOTHER
14. Maiden Name Francis Zerden
15. Birthplace Europe

16 (a) Informant Isaac E Levin
(b) Address 3817 Callaway Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-25-47 (month) (day) (year)
(c) Cemetery or crematory Levy Friendship Cem
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 206 Eutaw Place

19 (a) AUG 25 1947 (Date rec'd by registrar) (b) Huntington Woods, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 24 1947, at 7:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 23 1947 to Aug 24 1947, and that I last saw her alive on Aug. 24 1947

Immediate cause of death	Duration
Posterior - inferior cerebellar Thrombosis	3 days
Due to	
Due to	
Other Conditions Subacute glomerulo nephritis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert A Johnson M. D.
Address Mercy Hospital Date signed 8/24/47

G54548

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G54548

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 723 Bartlett Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 723 Bartlett Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PAULINE M. HERKENHEIN

3 (b) If veteran, name war ----
3 (c) Social Security Account No. ----

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Geo. H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 78 | Months | Days | If less than one day hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER 12. Name Robt. B. Young
13. Birthplace N.Y.

MOTHER 14. Maiden Name Anna Winters
15. Birthplace Balto.

16 (a) Informant Mrs. Ethel Mackubin
(b) Address 723 Bartlett Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/25/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location City

18 (a) Funeral director WIEDEFELD AND SON
(b) Address GREENMOUNT AVE & 22ND

AUG 25 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21st 1947, at 9:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 7 1947 to Aug 21 1947 and that I last saw h[illegible] alive on Aug 21 1947.

Immediate cause of death Coronary Vascular Disease — Duration 3 yrs

Due to

Due to

Other Conditions Varicose Ulcer X Leg

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fritz S Kinsey M. D.
Address 2700 Hartford Rd Date signed Aug 25 47

G54549

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 155

G54549 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) one
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State 4 (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2007 Barclay St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** William G. Reilly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5 1884

8. AGE: Years	Months	Days	If less than one day
62	10	17	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Store clerk

11. Industry or business

FATHER 12. Name Peter F. Reilly
13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Burke
15. Birthplace Ireland

16 (a) Informant Mrs. Wm. G. Reilly
(b) Address 2007 Barclay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/25/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location City

18 (a) Funeral director Wiedefeld and Son
(b) Address Greenmount Ave & 22nd

19 Date rec'd by registrar AUG 25 1947 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 22 1947 at 4:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 21 1947 to Aug. 22 1947 and that I last saw him alive on Aug. 22 1947

Immediate cause of death	Duration
ANEMIA	
Due to MEGAKARYOCYTIC MYELOID METAPLASIA	
Due to	
Other Conditions UREMIA	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. B. Scott M. D.
Address Mercy Hospital Date signed 8/22/47

G54550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G54550 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2037 N. Calvert St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2037 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM DAVIS MARTIN

3 (b) If veteran, name war: -----

3 (c) Social Security Account No. 215-18-9409

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary Vaughan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 75 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation Bookkeeper

11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace

16 (a) Informant Mrs. Mary Smith
(b) Address 2037 N. Calvert St.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 8/26/47 (month) (day) (year)
(c) Cemetery or crematory Greenmount City
Location

18 (a) Funeral director WIEDEFELD AND SON
(b) Address GREENMOUNT AVE & 22ND

AUG 25 1947 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 150 Patient is a patient [illegible] and I saw him while he lived in vacation.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/24/47 19... at 6:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/17 1947, to 8/24 1947, and that I last saw h.m alive on 8/19 1947.

Immediate cause of death	Duration
Cardiac Failure	
Coronary Thrombosis	
Due to arteriosclerotic Heart Dis.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. H. Townshend M. D.
Address 14 E. Eager St Date signed 8/25/47

G54551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

G54551 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2733 Fox St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frances Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/16/1923

8. AGE: Years: 23 | Months: 9 | Days: 6 | If less than one day: hr. min.

9. Birthplace Spartanburg, S.C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Will Williams

13. Birthplace S.C.

MOTHER 14. Maiden Name Janey Littlejohn

15. Birthplace S.C.

16 (a) Informant Mrs Ernestine Perrol

(b) Address 2733 Fox St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Spartanburg S.C.

Location

18 (a) Funeral director Chas R Logue

(b) Address 802 Madison Ave

AUG 25 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22 1947, at 11:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab wound of heart

Due to

Other Conditions Multiple stab wounds

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 8-22-47 at 10:10 P.M.

(b) Where did injury occur? 2733 Fox St.

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no

(d) Means of injury Sharp Instrument

23. Signature Howard J Mullen M.D. Medical Examiner.

Date signed 8-23-47

X

G54552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

G54552 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 813 W. 35th St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 813 W 35th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Anne Milway

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Edw. F. Milway

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7 - 1874

8. AGE: Years 73 | Months 6 | Days 15 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Wm. S. Pearce

13. Birthplace Md

MOTHER 14. Maiden Name Sarah Brandt

15. Birthplace Md

16 (a) Informant Miss Ethel Milway

(b) Address 813 W 35th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-25-47 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville Md

18 (a) Funeral director Geo. L. Mayer Jr

(b) Address 1512 Wallis St

(c) AUG 25 1947 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 22 1947 at 11 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10, 1945 to Aug 22 1947. and that I last saw him alive on Aug 22 1947.

Immediate cause of death: Carcinoma — Duration

Due to: of right lung

Due to: duration 3 yrs?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Leonard A. Wallenstein M.D.

Address 818 W 36th St Date signed 8-27-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G54553 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3339 Windsor Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3339 Windsor Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel B. Chambers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	widowed

6 (b) Name of husband or wife Nannie Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1873

8. AGE: Years	Months	Days	If less than one day
73	9	13	hr. min.

9. Birthplace Wash., D. C. (Town, county, and state)
10. Usual Occupation lawyer
11. Industry or business

FATHER
12. Name Benjamin Chambers
13. Birthplace Washington, D. C.

MOTHER
14. Maiden Name Rachel Tyler
15. Birthplace Ogdensburg, N. Y.

16 (a) Informant Benjamin Chambers
(b) Address 2502 Roslyn Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/25/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director John O. Mitchell & Sons, Incc.
(b) Address 1900 Eutaw Place

AUG 25 1947 (Date rec'd by Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22 1947, at 3:45 p.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/26 1946 to 8/22 1947 and that I last saw him alive on 8/22 1947.

	Duration
Immediate cause of death: Myocardial insufficiency	14 mo.
Due to Arteriosclerotic heart disease	14 mo.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert A. Reiter M.D.
Address Garrison & Windsor Ave. Date signed 8/23/47

G54554

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G54554 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3222 Fernwood
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3222 Fernwood
(If rural give location)
(e) Citizen of foreign country? Over (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond C. Cole

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of ~~husband or~~ wife Thelma Davis (Cochran)
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) July 23, 1894

8. AGE: Years	Months	Days	If less than one day
53		27	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation Lt. Police Dept
11. Industry or business Balto. City

FATHER
12. Name Wallace C. Cole
13. Birthplace Md

MOTHER
14. Maiden Name Sarah C Lapp
15. Birthplace Md

16 (a) Informant Mrs Raymond C. Cole
(b) Address 3222 Fernwood Ave

17 (a) Burial (b) Date thereof Aug. 25, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Longaine
Location Woodlawn, Md

18 (a) Funeral director Harry H Watzke
(b) Address 4101 Edmondson Ave

AUG 25 1947 (b) Huntington Williams M.D.
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 22, 1947, at 10:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 24 1939, to August 22 1947, and that I last saw him alive on August 21 1947.

Immediate cause of death	Duration
Coronary Thrombosis	1 min 8 days
Due to Angina Pectoris	8 yr. 9 da
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chester Riland, M. D.
Address 2532 Edmondson Ave Date signed 8-22-47

G54555 Bl#B-84699 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 161a Registered No. G54555

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5416 Denmore Avenue.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5416 Denmore Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME THOMAS A. COOPER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1947

8. AGE: Years | Months: 1 | Days: 32 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER 12. Name Leroy Cooper
13. Birthplace Balto Md

MOTHER 14. Maiden Name Alice Corsey
15. Birthplace Balto Md

16 (a) Informant John Corsey
(b) Address 5416 Denmore Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/25/47 (month) (day) (year)
(c) Cemetery or crematory St. Thomas Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. Lew. H. Holland
(b) Address 1651 Druid Hill Ave.

19 (a) AUG 25 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23, 1947, at 9.30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Atelectasis of lungs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 8-23-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54556

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X 83a

Registered No. G54556

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave.
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hours
(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Rural - Arbutus
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5524 Thomas Ave
(If rural give location) Arbutus
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Alice Christina Watt

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NO

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Married.

6 (b) Name of husband or wife James C. Watt
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) May 4 - 1898

8. AGE: Years	Months	Days	If less than one day
49	3	20	hr. min.

9. Birthplace Indian Orchard - Springfield, Mass.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business None

FATHER
12. Name William Lunan
13. Birthplace Scotland

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant JAMES C. WATT
(b) Address 5524 THOMAS AVE.

17 (a) Burial (b) Date thereof Aug. 26. 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 (a) AUG 25 1947 (b) Huntington Williams, M.D. Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/24 19 47, at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/23/19 47 to 8/24 19 47, and that I last saw h alive on 8/24 19 47.

Immediate cause of death Cerebral Hemorrhage due to Hypertension

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John M. Shaw M. D.
Address 5 E. Lynn Ave. Date signed 8/24/47

X

G54557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

G54557 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Balt St
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1829 Bank St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Hegdon Jr

3 (b) If veteran, name war: 2nd World War
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25, 1924

8. AGE: Years	Months	Days	If less than one day
23	4	28	hr. min.

9. Birthplace Balto
(Town, county, and state)
10. Usual Occupation Shearsman
11. Industry or business Mfg Corrugated

FATHER
12. Name William H. Hegdon Sr
13. Birthplace Balto

MOTHER
14. Maiden Name Alberta Lowman
15. Birthplace Md

16 (a) Informant William H. Hegdon Sr
(b) Address 1629 Bank St

17 (a) Burial (b) Date thereof Aug 29, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto National
Location Balto Co

18 (a) Funeral director A. Howard Evans
(b) Address 1400 Eastern Av

19 (a) AUG 25 1947 (b) Huntington Williams M.D.
(Date received by Registrar) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 1947, at 12 00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Crushed head involving all bones of head and face

Due to

Other Conditions Multiple lacerations, multiple fractures of long bones, and multiple bleeding wounds.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 23/3
(a) Date of injury 8-22-47 at 11:50 P.M.
(b) Where did injury occur Hanover nr. Dickman St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? no
(d) Means of injury Auto + Auto Collision

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 8-23-47

G54558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G54558 Registered No. 186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 39 E. Randall st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 39 E. Randall st.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Edward Jones

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 213-P-6515

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Annie M. Jones
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec 8, 1878
8. AGE: Years 68 | Months 8 | Days 15 | If less than one day hr. min.
9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Lawyer
11. Industry or business Estate Bros

FATHER
12. Name Dan'l Jones
13. Birthplace " "

MOTHER
14. Maiden Name " "
15. Birthplace " "

16 (a) Informant Mrs Emil Burch
(b) Address 39 E. Randall St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 27, 1947 (month) (day) (year)
(c) Cemetery or crematory Lindenridge Memorial
Location Howard Co
18 (a) Funeral director A. Rowland Collins
(b) Address 1110 Eshcol St.
19 (a) AUG 25 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 23, 1947, at 11 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
IMMEDIATE CAUSE OF DEATH Fractured Skull.
+ Fracture of Femur
Ventricular -
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8/23/47 at 23rd 10:30 A.M.
(b) Where did injury occur? 39 E. Randall st
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No.
(d) Means of injury Fell down stairs.

23. Signature Emil L. Burch M.D.
Medical Examiner
Date signed 8-23-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G54559

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G54559

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 691 GLADSTONE AVENUE
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 17 MOS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town BALTIMORE 10
(If outside city or town limits, write RURAL and give town)
(d) Street No. 691 GLADSTONE AVENUE
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL EMORY PENTZ

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	WIDOWED

6 (b) Name of husband or wife KATHERINE SHALLUS Pentz
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) FEB 28 1866

8. AGE: Years	Months	Days	If less than one day
81	5	28	hr. min.

9. Birthplace BALTIMORE (Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business —

FATHER
12. Name EMORY PENTZ
13. Birthplace MARYLAND

MOTHER
14. Maiden Name MARY LEE
15. Birthplace MARYLAND

16 (a) Informant J.O. ZIEGFELD
(b) Address 691 GLADSTONE AVE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/26/47 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 AUG 25 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 24 1947, at 6:53 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from JULY 1946 to AUG 1947 and that I last saw h.im. alive on AUG 23 1947.

Immediate cause of death CONGESTIVE HEART FAILURE — Duration 1 WK

Due to ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE — Duration 1?

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John M. Scott M. D.
Address 8 LONGWOOD ROAD Date signed AUG 24

X

G54560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G54560 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 132 E Read St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Annie Washington Stokes.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mr. Ira B. Stokes

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) May 4, 1875

8. AGE: Years 72 | Months 3 | Days 19 | If less than one day ... hr. ... min.

9. Birthplace Crisfield Md.
(Town, county, and state)

10. Usual Occupation Home maker

11. Industry or business Home maker.

FATHER
12. Name Wesley R Miles
13. Birthplace Crisfield Md

MOTHER
14. Maiden Name Louisa Dougherty
15. Birthplace Crisfield Md

16 (a) Informant Mrs Ira B Stokes
(b) Address 132 E Read St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/26/47 (month) (day) (year)
(c) Cemetery or crematory Crisfield Cem.
Location Crisfield, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

AUG 25 1947

19 (a) ... (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 23 1947, at 1 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 23 1947 to Aug 23 1947, and that I last saw h.. alive on Aug 23 1947.

Immediate cause of death Asphyxiation by the mechanical obstruction of the foreign bronchus

Due to Arteriosclerotic heart disease

Due to —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Asphyxiation; foreign bronchus

Duration
30 min
20 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David Bodansky. M. D.
Address Church Home Hosp. Date signed 8/23/47

X

G54561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 51B

Registered No. G54561

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4008 Dorchester Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William P. Beverle, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Hannah Louise Beverle
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Nov. 2, 1878

8. AGE: Years	Months	Days	If less than one day
68	9	22	hr. min.

9. Birthplace Bernville Pennsylvania
(Town, county, and state)
10. Usual Occupation Retired Elec. Engineer
11. Industry or business Gas Co.

FATHER
12. Name Dr. Wellington George Beverle
13. Birthplace Penna. - Bernville

MOTHER
14. Maiden Name Anna Hine
15. Birthplace Penn. (Bernville)

16 (a) Informant Mrs. Hannah Louise Beverle
(b) Address 4008 Dorchester Rd., Balt. 7,

17 (a) Burial (b) Date thereof 8/27/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Mausoleum
Location Woodlawn, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) AUG 25 1947 Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 1947, at 6:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 3 1947, to Aug 24 1947, and that I last saw h alive on Aug 23 1947.

Immediate cause of death	Duration
Cardiac - Respiratory failure	
Due to Ca of Prostate	
Due to	
Other Conditions Arterio Sclerosis Gen. Chronic nephritis, Hypertension Ur. Dis.	

(Include pregnancy within 3 months of death)

Date of operation 8/1/47
Major findings of operation: Ca of Prostate
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dan'l T. Beatty M. D.
Address Union Memorial Hospital Date signed 8-24-47

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

469

G54562 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2729 W. Mosher St.
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 86 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2729 W. Mosher St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN PHILIP CONRAD

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	229-07-2258A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Dorothy M. Conrad
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1860

8. AGE: Years	Months	Days	If less than one day
86	10	11	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Philip Conrad
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Miss Eva A. Conrad
(b) Address 843 McCable Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk. Mem.
Location Balto. Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17. Md

AUG 25 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 20, 1947 at 7:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 4 1947 to Aug 20 1947 and that I last saw him alive on Aug 19 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to Carcinoma of Pancreas	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Scagnetti M. D.
Address 1729 W Lombard St. Date signed Aug 21/47

G54563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 116

Registered No. G54563

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 Mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Texas (b) County
(c) City or town Corsicana (If outside city or town limits, write RURAL and give town)
(d) Street No. 644 W. 6th Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Victor Carruthers VICTOR HUGO CARRUTHERS

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Tomamye

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-5-91

8. AGE: Years 55 | Months 8 | Days 18 | If less than one day hr. min.

9. Birthplace Texas Corsicana (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business U. S. Gov't

FATHER 12. Name Frances W Carruthers

13. Birthplace Ga

MOTHER 14. Maiden Name Mary Emma Hallman

15. Birthplace Fla

16 (a) Informant Records Mrs. T. Carruthers

(b) Address Corsicana, Tex.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/25/47 (month) (day) (year)

(c) Cemetery ~~Crematory~~ Oakwood

Location Corsicana, Tex.

18 (a) Funeral director Wm. J. TICKNER & SON, M.C.

(b) Address North & Pa. Aves. Balto. 17, Md.

AUG 25 1947 (Date received by registrar) (b)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 1947 at 10 a M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1947, to Aug 23 1947, and that I last saw him alive on Aug 23 1947.

Immediate cause of death: Pericardial tamponade ?

Due to Mediastinal ? Mycosis ?

Due to Post-Pleurotomy

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 5-27-47

Major findings of operation: Left empyema

of autopsy: Not done

Duration: 1 week

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.

Address [illegible] Date signed 8-23-47

G54564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V13B

Registered No. G54564

Every item of information should be carefully supplied. The... write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 19
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 W. Fayette St. (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME William T. Briscoe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Male | 5 Color or race: Colored | 6 (a) Single, married, widowed, or divorced: ?

6 (b) Name of husband or wife: ?

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 7-18-24

8. AGE: Years 24 | Months —1 | Days —2 | If less than one day ——hr. ——min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation.....

11. Industry or business.....

FATHER 12. Name Robert L. Briscoe
13. Birthplace Md.

MOTHER 14. Maiden Name Ethel McCampbell
15. Birthplace Md.

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-25-47 (month) (day) (year)
(c) Cemetery or crematory Int. a. Calvary
Location.....

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 (a) AUG 25 1947 Huntington Williams, M.D. Registrar
(Date received by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-20 19 47 at 8:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-17 19 47 to 8-20 19 47, and that I last saw ~~him~~ alive on 8-20 1947.

Immediate cause of death	Duration
miliary tuberculosis	4 mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature J. H. Lisson M. D.
Address Johns Hopkins Hosp. Date signed 8 Aug 47

X

G54565

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 937

Registered No. G54565

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2217 Linden Ave.
(c) Hospital or institution: 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2217 Linden Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MILTON HIRSHBERG.

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-3504

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Bertie B. Hirshberg
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19, 1881

8. AGE: Years	Months	Days	If less than one day
65	10	5	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired.
11. Industry or business

FATHER
12. Name Moses Hirshberg,
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Sarah Goldsmith,
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Bertie B. Hirshberg
(b) Address 2217 Linden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/26/47. (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Baltimore, Md.

18 (a) Funeral director Harris Sonnenstein & Son
(b) Address 1902 Eutaw Place.

19 AUG 25 1947 Registered by Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 24th. 1947, at A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1947 to Aug 21 1947 and that I last saw h[im] alive on Aug 21 1947.

	Duration
Immediate cause of death Coronary thrombosis, myocardial infarction	½ hr.
Due to Arteriosclerotic heart disease	5 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry D. Chamberlain M.D.
Address 1101 St. Paul St. Date signed

VS 150

G54566

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G54566

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd St & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 8 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Pikesville, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 29 Walker Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Russel Caltrider

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-01-3089

4. Sex: Male

5. Color or race: White

6 (~~a~~) ~~Single~~, married, ~~widowed~~, or ~~divorced~~: MARRIED

6 (b) Name of husband or wife: Maud Marie Cartrider

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-29-1896

8. AGE: Years 50 | Months 11 | Days 24 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Greens Keeper

11. Industry or business

FATHER
12. Name John Caltrider
13. Birthplace Penn.

MOTHER
14. Maiden Name Florence Ford
15. Birthplace Maryland

16 (a) Informant MAUD M. CALTRIDER.
(b) Address 29 WALKER AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 26/47 (month), (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Thos. J. Bowman & Son
(b) Address 3615-17 Chestnut Ave

19 AUG 25 1947 (Date accepted) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-22 1947, at 9:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-17 1947 to 8-22 1947, and that I last saw h.i.m. alive on 8-22 1947.

	Duration
Immediate cause of death: Myocardial infarction	1 wk.
Due to: Arteriosclerotic Heart Disease	5 yr.
Due to:	
Other Conditions: Diabetes Mellitus	15 yr.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Coronary sclerosis, Acute congestion

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman R. Freeman, M.D.
Address Union Memorial Hosp. Date signed Aug 25 47

61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54567

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G54567

Please write the causes of death clearly and legibly. The correct age is especially important. Physicians: please write or typewrite answers to all items supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 713 S. Milton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Felip Spiock

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-09-6608

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Anna
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) 1/23/04

8. AGE: Years	Months	Days	If less than one day
43	6	29	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Reamer
11. Industry or business Shipbuilding

FATHER
12. Name George Spiock
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Dul
15. Birthplace Poland

16 (a) Informant Mrs. Anna Spiock
(b) Address 713 S. Milton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/26/47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Road

18 (a) Funeral director M. J. Dodrill & Son
(b) Address 1808 Eastern Ave

19 AUG 25 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/21 1947, at 9:15 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D. Medical Examiner
Date signed 8/22/47

G54568

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓167

G54568 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 152 N. Exeter St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Roles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1904

8. AGE: Years	Months	Days	If less than one day
43	6	-	hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward Roles
13. Birthplace Md.

MOTHER
14. Maiden Name Elnora Dose
15. Birthplace Md.

16 (a) Informant Mary Wilson
(b) Address 152 N. Exeter St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy A. Wilson
(b) Address 1000 Brantly Ave

19 AUG 25 1947 (Date rec'd by registrar) Huntington Williams

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22 1947, at 9 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Stab wound of abdomen

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-22-47 at 8:30 P M.
(b) Where did injury occur? 152 N. Exeter St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Sharp instrument

23. Signature Emil H. Kemp M.D.
Medical Examiner
Date signed 8-23-47

G54569

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1947

G54569
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 404 Myrtle Ave,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 404 Myrtle Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Berta - Bertie - Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Elias Johnson.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31, 1893

8. AGE: Years 54 | Months 4 | Days 21 | If less than one day hr. min.

9. Birthplace Charlottesville Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown.
13. Birthplace

MOTHER
14. Maiden Name Rachel Pryor.
15. Birthplace Virginia

16 (a) Informant George Talbott.
(b) Address 404 Myrtle Ave.

17 (a) Burial (b) Date thereof 8-25-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Inta K. R. Williams
(b) Address 327 N. Schroeder St.

AUG 25 1947
(Date rec'd by registrar)

(b) Huntington Williams M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21, 1947, at 3:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 19, 1947 to Aug 21, 1947 and that I last saw h[illegible] alive on Aug 21, 1947

Immediate cause of death	Duration
Cerebral Hemmorhage	3 days
Due to Cardio-Vascular Disease	8 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ulysses Bando M. D.

Address 2445 N. Hill Ave. Date signed 8-25-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54570 — BALTIMORE CITY HEALTH DEPARTMENT — G54570

CERTIFICATE OF DEATH 1310

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2338 N. Howard (8)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Zelma White

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Negro	Married (Sep)

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1908

8. AGE: Years	Months	Days	If less than one day
39			hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Sales clerk
11. Industry or business

FATHER
12. Name Riddick Stevens
13. Birthplace North Carolina

MOTHER
14. Maiden Name Victoria Britt
15. Birthplace North Carolina

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof 8-25-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St.

AUG 25 1947 Huntington Williams
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21 1947, at 9.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 11 1947 to Aug 21 1947 and that I last saw h[illegible] alive on Aug 21 19 47

Immediate cause of death Uremia — Duration

Due to Renal failure

Due to Hypertensive Cardio-Vascular Renal Disease

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. B. Kearns M. D.
Address University Hosp Date signed 8-21-47

G54571

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122

G54571
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1043 W. Lexington
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1043 W. Lexington
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel J. Davis.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Martha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31, 1888

8. AGE: Years: 59 | Months: 4 | Days: 20 | If less than one day: hr. min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER
12. Name: Jacob H. Davis
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Elizabeth Morton.
15. Birthplace: Melfa, Va.,

16 (a) Informant: Mrs. Martha Davis,
(b) Address: 1043 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-25-1947 (month) (day) (year)
(c) Cemetery or crematory: Mt. Auburn
Location:

18 (a) Funeral director: Mrs. Katie B. Williams
(b) Address: 322 W. Schroeder St.

19 (a) 5 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/20/47 19 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/6/47 19 , to 8/20/47 19 , and that I last saw h alive on 8/19/47 19 .

Immediate cause of death: Acute Myocarditis
Due to: Nephritis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration: 2 hours

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Walter J. Loomis
Address: 402 Edmondson Date signed 8/22/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

G54572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G54572 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1334 N. Washington St.
(c) Hospital or institution: 8

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1334 N. Washington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie A. Butler

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife James M. Butler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 14, 1898

8. AGE: Years	Months	Days	If less than one day
49	4	8	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Hugh J. Reynolds
13. Birthplace SC

MOTHER
14. Maiden Name Ellen Healy
15. Birthplace Balto. Md.

16 (a) Informant
(b) Address 1334 N. Washington St.

17 (a) Burial (b) Date thereof Aug. 26/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto. Md.
18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Orleans St.
19 (a) Filed AUG 25 1947 (b) by registrar Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22/47 19 at 4.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 27 1947 to Aug 22 1947 and that I last saw her alive on Aug 22 1947

Immediate cause of death	Duration
Primary Carcinoma of Cervix	6 Months
Due to Epithelioma of Cervix	1 Year
Due to	
Other Conditions Cerebral Hemorrhage	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. Joseph G. Clemens M. D.
Address 26 E. Preston St. Date signed Aug 25 1947

Balto. 2. Md.

G54573 BALTIMORE CITY HEALTH DEPARTMENT G54573
Registered No.

CERTIFICATE OF DEATH 1947

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A.
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1210 Mt. Royal Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter J. Kelly

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-10-7602

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
72			hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name Kelly
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Kathleen Masel
(b) Address 2011 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/27/47 (month) (day) (year)
(c) Cemetery or crematory Moreland
Location Baltimore

18 (a) Funeral director Philip Henry Sons
(b) Address 222 Orleans St

AUG 25 1947 (a) (b) Washington Williamsport Md.
(Date rec'd by registrar) (Registrar)

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/23 1947, at 5:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic CV disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Fulbright M.D.
Medical Examiner.
Date signed 8/24/47

(Correct age is especially important. Physicians: please write the causes of death clearly and legibly.)

G54574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G54574
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 350 Rosebank Ave.
(c) Hospital or institution:
57
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore -12
(If outside city or town limits, write RURAL and give town)
(d) Street No. 350 Rosebank Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Louise Muller

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Thomas Kelso Muller

6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) Dec. 2. 1867

8. AGE: Years 79 | Months 8 | Days 20 | If less than one day ..... hr. ..... min.

9. Birthplace New Jersey
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Jackson
13. Birthplace England

MOTHER
14. Maiden Name Sarah Brock
15. Birthplace New Jersey

16 (a) Informant Miss Gladys Muller
(b) Address 350 Rosebank Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 25. 1947 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Cem.
Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address Baltimore Maryland

19 (a) AUG 25 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 August 1947, at 7:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐, and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to Hypertensive Arteriosclerotic Heart Disease.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer, Jr. M.D. Medical Examiner.
Date signed 23 Aug. 1947

X

Complete the causes of death clearly and legibly. Cause of death is especially important. Physicians: please write the

G54575

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓61

G54575 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Balti. gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2042 Cliftwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Tomi Polidoro (ANTONIO POLIDORO)

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 212-09-6384-1

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Connie Polidoro (Concittina Diforte) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) Jul. 29. 1893

8. AGE: Years 51 | Months 0 | Days 26 | If less than one day: hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation

11. Industry or business: Amer. Sugar Refinery

FATHER — 12. Name: Nicola Polidoro
13. Birthplace: Italy

MOTHER — 14. Maiden Name: Not Known
15. Birthplace: Italy

16 (a) Informant: Mrs. Concittina Polidoro (Wife)
(b) Address: 2042 Cliftwood Ave. - 13

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug. 27. 1947 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer Cem.
Location: Baltimore Md.

18 (a) Funeral director: HENRY SANDER & SONS. INC.
(b) Address: BALTIMORE MARYLAND.

19 (a) AUG 26 1947 (b) Huntington Mills Baltimore

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/24 1947, at 12:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/29 1947 to 8/24 1947, and that I last saw h[illegible] alive on 8/24 1947

Immediate cause of death: Acute Cardiac failure — Duration

Due to: circulatory collapse

Due to: Mesenteric Thrombosis

Other Conditions: Portal cirrhosis, Diabetes mellitus
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Autopsy done 8/25/47

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. D. Cooper

Address S. B. 9. 17. Date signed 8/26/47 M. D.

99

PHYSICIAN
Underline the cause to which death should be charged statistically.

G54576

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46B

G54576 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun Sts.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2503 Strathmore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth B Brolle

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Hugo Brolle
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) 10-20-87

8. AGE: Years	Months	Days	If less than one day
59	10	3	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation H. W.
11. Industry or business

FATHER 12. Name William Easterman
13. Birthplace Germany

MOTHER 14. Maiden Name Sophia Steffan
15. Birthplace Germany

16 (a) Informant Husband Hugo Brolle
(b) Address 2503 same Strathmore Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/26/47 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore, Md

18 (a) Funeral director Leonard Hyatt
(b) Address 5365 Roosevelt Rd

19 1947 (b) (Date rec'd by registrar) Registrar

Transfer to Hillsboro, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-23 1947, at 3:22 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 20 Aug 1947, to 23 Aug 1947, and that I last saw h[illegible] alive on 23 Aug 1947.

Immediate cause of death Bronchopneumonia — Duration

Due to Carcinoma of stomach

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 22 Aug 47

Major findings of operation Carcinoma of stomach

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Vincent A. Lacace M.D.
Address Franklin Sq. Hosp Date signed 23 Aug 47

G54577 BALTIMORE CITY HEALTH DEPARTMENT G54577
CERTIFICATE OF DEATH 47c Registered No.

Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3025 GUILFORD AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3025 Guilford ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY F. BECKER

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 31 1881

8. AGE: Years	Months	Days	If less than one day
66	0	23	hr. min.

9. Birthplace BALTO. Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name JOHN BECKER
13. Birthplace GERMANY

MOTHER
14. Maiden Name MARY LINNEBERG
15. Birthplace GERMANY

16 (a) Informant MARY BECKER
(b) Address 3025 Guilford ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 24 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md.

18 (a) Funeral director Henry F. Jenkins & Son
(b) Address McCulloh & Orchard

19 (a) (Date received by registrar) (b) Registrar

AUG 25 1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 23, 1947, at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Aug 23 1947 and that I last saw him alive on Aug 23 1947

Immediate cause of death — Acute Cardiac failure — Duration —
Due to — Bronchopneumonia —
Due to — Arteriosclerosis —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L B Stevens M.D.
Address 3400 Eastern ave Date signed 8/26/47

Huntington Williams, M.D.

G54578 — Folderauer — 13B — G54578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G54578

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 221 N. Patterson Park Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 221 N. Patterson Park Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Anna Folderauer

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-6036

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	

6 (b) Name of husband or wife John
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8-1893

8. AGE: Years	Months	Days	If less than one day
54	4	15	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Seamstress
11. Industry or business

FATHER
12. Name John Paletor
13. Birthplace Germany.

MOTHER
14. Maiden Name Mary Seffner
15. Birthplace Germany

16 (a) Informant John Folderauer
(b) Address 211 N. Patterson Park ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/26/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director W. W. E. Doggett & Sons
(b) Address Lombard & Bond Sts.

19 AUG 25 1947 (Signature of Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 – 1947, at 11:45 a M

21. I certify that death occurred on the date above stated; that I attended deceased from January 7 – 1947 to August 23 1947, and that I last saw h.h. alive on August 22 1947.

Immediate cause of death	Duration
Pulmonary Tuberculosis	3 years.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Chester Riland, M.D.
Address 2532 Edmondson Ave. Date signed 8-23-47.

X

G54579

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 101

Registered No. G54579

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 68 days
(e) Length of stay in Baltimore (yrs., mos., or days) 68 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mass. (b) County New Bedford
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 335 Shaw St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Eugenius John Hamot

3 (b) If veteran, name war

3 (c) Social Security Account No. 018-07-7753

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 11, 1919

8. AGE: Years	Months	Days	If less than one day
28	7	13	hr. min.

9. Birthplace New Bedford, Mass. (Town, county, and state)
10. Usual Occupation AB seaman
11. Industry or business Seafarer

FATHER
12. Name Anthony Hamot
13. Birthplace Poland

MOTHER
14. Maiden Name Agnes Iodpski
15. Birthplace Poland

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-28-47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem. #2
Location New Bedford Mass

18 (a) Funeral director John M. Weber
(b) Address 40 S. Chester Street

19 (a) (b) (Signature of Registrar)

AUG 25 1947 Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 24 19 47, at 11:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 19 47 to Aug. 24 19 47, and that I last saw him alive on Aug. 24 19 47.

Immediate cause of death Acute leukemia — Duration 2 mos.

Due to Generalized lymphadenopathy

Due to Massive generalized petechial hemorrhage — Approx. one day

Other Conditions Marked pulmonary congestion and edema
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rheim M. Jones
Rheim M. Jones, SA Surgeon M. D.
Address US Marine Hospital Date signed 8/25/47

X

G54580

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G54580 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 S Chapel Gate Lane
(c) Hospital or institution: Pinecrest Sanitorium
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Worcester
(c) City or town Pocomoke (If outside city or town limits, write RURAL and give town)
(d) Street No. Market Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Laura L (Renninger) Renninger

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed.

6 (b) Name of husband or wife: Harry D. Renninger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 4, 1869

8. AGE: Years 77 | Months 11 | Days 21 | If less than one day hr. min.

9. Birthplace Delmar, Delaware (Town, county, and State)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Wm. S. Marvil

13. Birthplace Delaware

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Charles Renninger

(b) Address Pocomoke, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-27-1947 (month) (day) (year)

(c) Cemetery or crematory Presbyterian Cem

Location Pocomoke Md

18 (a) Funeral director Dennis & Watson

(b) Address Pocomoke City Md

19 (a) (Date received by registrar) (b) Registrar

AUG 28 1947

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 25 1947, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/8 1947 to 8/25 1947 and that I last saw her alive on 8/25 1947.

Immediate cause of death: Cardiac Vascular collapse — Duration: 2 days

Due to

Due to

Other Conditions: Senile psychosis ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Samuel P. Glazer M. D.

Address 3516 Talbot Ave Date signed

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54581 CWK-112846

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G54581

Every item of information should be carefully supplied. Do not abbreviate, write plainly, with pen and ink. Physicians: please write the causes of death clearly and legibly. Be sure that age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 113 W. Franklin Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Nicholas Wiederbacher or Weidall
Social Security 264-09-7529

3 (b) If veteran, name war

3 (c) Social Security Account No. 264-09-7529

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23-1897

8. AGE: Years	Months	Days	If less than one day
49	8	2	hr. min.

9. Birthplace Ohio
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Nicholas Wiederbacher
13. Birthplace Ohio

MOTHER
14. Maiden Name Emma Flamm
15. Birthplace Ohio

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) shipped (b) Date thereof 8/25/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Cinn. Ohio

18 (a) Funeral director David Sondheim & Son
(b) Address 1902 Eutaw Place

19 AUG 25 1947 (b) Huntington Williams M.D.
Date received by Registrar Signature of Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1947, at 4:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 8 1947 to Aug. 25 1947, and that I last saw h. 1m alive on Aug. 25 1947.

Immediate cause of death	Duration
Respiratory failure	24a
Due to Tuberculosis of Lungs for advanced	5 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph J Bowen Jr. M.D.
Address Balto City Hosp Date signed 8-21-47

G54582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83A

G54582
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Marlborough Apts - E C
(b) Street address Eutaw & Oliver & Lanvale Sts
(c) Hospital or institution: 14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and name)
(d) Street No. Marlborough Apts - Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Brown

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 30 / 186

8. AGE: Years 79 | Months 10 | Days 26 | If less than one day hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Sol Brown
13. Birthplace Germany

MOTHER
14. Maiden Name Eva Fredgreech
15. Birthplace America

16 (a) Informant Oscar M Brown
(b) Address Marlborough Apts - 85

17 (a) Burial (b) Date thereof Aug 27/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto Hebrew Cem
Location Edmondson

18 (a) Funeral director J. Abrams & Co
Address 2437 Pasterstown Rd

(Date rec'd by registrar) (b)

AUG 25 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1947, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/8 1946 to 8/25 1947
and that I last saw h[illegible] alive on 3/29 1947

Immediate cause of death Cerebral hemorrhage — Duration

Due to cerebral arteriosclerosis

Due to

Other Conditions senile dementia of long standing
(Including pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: not performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard D Hahn M D
Address Marlborough Apts Date signed 8/25/47 M. D.

Balto 17 Md Hahn

54583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30D

G54583
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 101 E. 33d St.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ~~Baltimore~~
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W. Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Wm. Joseph J. Johns

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1863

8. AGE: Years 83 | Months 11 | Days 3 | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William A. Johns
13. Birthplace Ireland

MOTHER
14. Maiden Name Eliza Franklin
15. Birthplace Ireland

16 (a) Informant Miss Catherine Allen
(b) Address Aged Woman's Home

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Aug. 27, 1947 (month) (day) (year)
(c) Cemetery or crematory ABINGDON
Location ABINGDON, MARYLAND

18 (a) Funeral director WILLIAM COOK, INC
(b) Address 1217 ST. PAUL ST.

19 AUG 26 1947 (Date rec'd by Registrar) (b) Huntington for Williams Mfr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 24 1947 at 11:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-18 1947 to 8-24 1947, and that I last saw him alive on 8-24 1947

Immediate cause of death Peripheral Vasc. Collapse; Uremia — Duration 1 wk

Due to Arteriosclerotic Heart Disease

Due to [redacted] Aneurysm of Abd. aorta. ? Generalized Arteriosclerosis ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Generalized arteriosclerosis

of autopsy: Aneurysm of Abd. aorta

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman R. Freeman M.D.
Address Union Memorial Hosp. Date signed 25 Aug 47

VS 150

X

G54584

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51C

Registered No. G54584

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2226 Poplar Grove Street
(c) Hospital or institution: 15-P
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2226 Poplar Grove Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Browne Linder

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Margaret Louise
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1906

8. AGE: Years	Months	Days	If less than one day
41	3	9	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Male Nurse
11. Industry or business St. Joseph's Hospital

FATHER
12. Name Conrad C. Linder
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Minnie Gorman Browne
15. Birthplace Maryland

16. (a) Informant Margaret L. Linder
(b) Address 2226 Poplar Grove Street

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 8/26/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 AUG 26 1947 (b) Date rec'd by registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23, 1947, at 9:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1946, to Aug 23 1947, and that I last saw him alive on Aug 23 1947.

Immediate cause of death	Duration
Bas. Pleuro-Pneumonia of Left Lung	9 days
Due to Retroperitoneal Carcinoma	13 Months
Due to Primary Carcinoma of Left Testicle	15 Months
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Carcinoma of Left Testicle
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William L. Keighley M.D.
Address 10 E. Biddle St. Date signed 8/27/47

54585 43158

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1249

G54585 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 8-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1417 N. Washington Pl.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond Soder

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-8-'11

8. AGE: Years	Months	Days	If less than one day
36	0	16	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Musician
11. Industry or business

FATHER
12. Name Raymond Soder
13. Birthplace Lyntuckey

MOTHER
14. Maiden Name Cicelia Harlem
15. Birthplace New York

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof AUG 26 1947 (month) (day) (year)
(c) Cemetery or crematory CALVARY + ALLIED CEM.
Location NEW YORK, N.Y.

18 (a) Funeral director WILLIAM COOK INC.
(b) Address 1217 ST. PAUL ST.

19 AUG 26 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 24 1947 at 4 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 23 1947 to Aug 24 1947 and that I last saw him alive on Aug 24 1947

Immediate cause of death	Duration
Leukemia	3 days
Hemorrhage from Esophageal Varices	
Due to	
Leukemia Cornhoms	1 Month
Due to	
Other Conditions Pulmonary edema	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: —
of autopsy: Gen. note liver, pulmonary edema, blood in GI tract

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Thomas E. Van Metre JR. M. D.
Address Johns Hopkins Hosp Baltimore Md. Date signed

G54586

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 46B

G54586 Registered No.

LW 112555

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 25-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1329 Binder Ct.-Fairfield (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Williams, Al

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of ~~husband~~ or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July-10-1903

8. AGE: Years	Months	Days	If less than one day
44	1	11	hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Meley
13. Birthplace N.C.

MOTHER
14. Maiden Name Lucy Smith
15. Birthplace N.C.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 26 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Balto Co. Md.

18 (a) Funeral director Robt E Williams
(b) Address 1515 McCulloh St.

19 (a) AUG 26 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21 1947 6:25A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 28 1947 to Aug. 21 1947, and that I last saw h~~e~~im alive on Aug. 21 1947

Immediate cause of death	Duration
Respiratory Failure	6 da
Due to Tuberculosis of Lungs for advanced	5 mo
Due to	
Other Conditions Metastasis from Carcinoma of Stomach (Include pregnancy within 3 months of death)	10 mo

Date of operation Nov. 1946
Major findings of operation: Carcinoma of Stomach.
of autopsy: see above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph J Bowen M.D.
Address Balto City Hosp Date signed 8-22-47

133

G54587

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 93D

Registered No. G54587

INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Daniels
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie May Pilcher

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	married

6 (b) Name of husband or wife Geo T Pilcher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 30, 1890

8. AGE: Years	Months	Days	If less than one day
57	6	27	hr. min.

9. Birthplace Luray Va (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name John Shank
13. Birthplace Va

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Geo T Pilcher
(b) Address Daniels Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-27-47 (month) (day) (year)
(c) Cemetery or crematory Good Shepherd
Location Ellicott City Md

18 (a) Funeral director H. Heyenbrohm
(b) Address Ellicott City Md

AUG 26 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 19 47 at 7:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from August 22 19 47 to Aug. 25 19 47 and that I last saw her alive on Aug. 25 19 47

Immediate cause of death	Duration
Cardiac Decompensation	
Due to Auricular Fibrillation	
Due to Hypertension C-V. Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22, If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. A. Hightower M. D.
Address University Hosp Date signed 8-25-47

VS 150

G54588

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47 C

G54588 Registered No.

Every item of information should be carefully supplied. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3414 Belair Road
(c) Hospital or institution: 27-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3414 Belair Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME AMELIA A. ARMSTRONG

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Geo. T. Armstrong
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6th, 187[illegible]

8. AGE: Years	Months	Days	If less than one day
73	4	18	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER 12. Name John Abel
13. Birthplace Germany

MOTHER 14. Maiden Name Marguerite Lutz
15. Birthplace Germany

16 (a) Informant Mrs. Marguerite Andrewjeski
(b) Address 6402 Rosemont Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 8/28/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. North Ave.

18 (a) Funeral director Leasch Funeral Home
(b) Address 7401 Belair Road

19 (a) AUG 26 1947 (Date received by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH August 24th 1947, at 9:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to Aug 24 1947 and that I last saw h[illegible] alive on 8/23/47

Immediate cause of death Acute Cardiac Failure — Duration
Due to Bronchopneumonia — Duration
Due to Pneumonia — Duration
Other Conditions — Duration
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. B. Stevens M.D.
Address 3400 Reisterstown Rd Date signed 8/26/47

4589

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

G54589 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital 4-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 125 Cheapside - Baldwin Hotel (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM COLEMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1895

8. AGE: Years	Months	Days	If less than one day
70 72	3	1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Alexander Coleman
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Hartlove
15. Birthplace Md.

16 (a) Informant Mrs. Edna M. Coleman
(b) Address 1403 S. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/27/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location 2930 Fred Road

18 (a) Funeral director John Conway & Son
(b) Address 901-03 E. Baltimore St.

19 AUG 26 1947 (Date received by local registrar) (Huntington Williams M.D. Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25, 1947, at 1.10 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Merrill M.D. Medical Examiner.
Date signed 8-25-47

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1949

Registered No. G54590

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2334 Edmondson Ave.
(c) Hospital or institution: 16-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2334 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN SOMMERS

3 (b) If veteran, name war: -

3 (c) Social Security Account No. 212-05-7117

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Margaret C. Sommers (nee Blake)
6 (c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Feb. 6, 1897

8. AGE: Years	Months	Days	If less than one day
50	6	18	... hr. ... min.

9. Birthplace Philadelphia, Pa. (Town, county, and state)
10. Usual Occupation
11. Industry or business Gas & Electric Co.

FATHER
12. Name George G. Sommers
13. Birthplace Baltimore

MOTHER
14. Maiden Name Annie Killmond
15. Birthplace Balto.

16 (a) Informant Mrs. Margaret C. Sommers
(b) Address 2334 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 26, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

AUG 26 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 24, 47 19... at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 18 1947 to Aug 24 1947 and that I last saw h[im] alive on Aug 23 19 47

Immediate cause of death	Duration
Coronary Occlusion	1 day
Due to Myocardial Ischemia	1 yr.
Due to	
Other Conditions Hypertension & arteriosclerosis (Include pregnancy within 3 months of death)	1 mo.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Homer H. Todd M. D.
Address 2108 St Paul St. Date signed 8/25/47

VS 150

G54591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94A

Registered No. G54591

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 730 Reservoir St.
(c) Hospital or institution: 13-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 730 Reservoir St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph H. St Martin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Louise M. St. Martin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 24, 1887

8. AGE: Years	Months	Days	If less than one day
59	9	1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Real Estate Operator
11. Industry or business Self

FATHER
12. Name Joseph H. St. Martin
13. Birthplace Louisiana

MOTHER
14. Maiden Name Martha Badders
15. Birthplace Md.

16 (a) Informant Miss Marie L. St. Martin
(b) Address 4003 Fernhill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/27/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, M d.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 AUG 26 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1947, at 10:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary artery disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 8/25/47

54592

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G54592 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3613 Walbrook avenue
(c) Hospital or institution: 15-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3013 Walbrook Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILMER Henley

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anna V. Henley (nee Pryor) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 11, 1882

8. AGE: Years	Months	Days	If less than one day
64	8	14	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Anna V. Henley
(b) Address 3013 Walbrook Ave.

17 (a) Burial (b) Date thereof 8/28/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 AUG 26 1947 Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25, 1947, at 1 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Macelvio M.D.
Medical Examiner.
Date signed 8/25/47

VS 121

Write the causes of death clearly and legibly. Use only black ink. Do not use pencil. Do not write above or below lines. Be brief but complete. Spell out full words. Do not abbreviate. If none, write none. If unknown, state so. Do not leave any space blank. If deceased was not attended during last illness, state fact and investigate immediately. Please write

54593

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1248

G54593
Registered No.

Please WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident 13-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2440 David Hill
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie Cornish

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: (Widow)

6 (b) Name of husband or wife: Wm. Cornish

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug-19-1894

8. AGE: Years 55 | Months 0 | Days 5 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name James Wright
13. Birthplace Md

MOTHER
14. Maiden Name Mary Smith
15. Birthplace Md

16 (a) Informant Mrs. Wilda Coates

(b) Address 2440 David Hill Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-28-47 (month) (day) (year)

(c) Cemetery or crematory Laurel Cem.
Location Baltimore Md

18 (a) Funeral director Mrs. Frances A. Hemsley

(b) Address 518 W. Biddle St.

AUG 26 1947 Washington Williams
(Date received by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/24 1947, at 9:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/24 1947 to 8/24 1947, and that I last saw h Cr alive on 8/24 1947.

Immediate cause of death: Ruptured Esophageal Varices — Duration

Due to: Cirrhosis of Liver

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature J. Burton Grant M.D.
Address 1514 Division Date signed 8/25/47

54591 B.C.H. 068061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1950

Registered No. G54591

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto City Hospitals 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) dea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 729 W. Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 14 1947

8. AGE: Years	Months	Days	If less than one day
	7	10	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Berman Johnson.
13. Birthplace Magothy, Md.

MOTHER
14. Maiden Name Betty B. Brown,
15. Birthplace Richmond, Virginia

16 (a) Informant Mrs Betty Johnson.
(b) Address 25 W. Fremont Ave.,

17 (a) Burial (b) Date thereof 8-26-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St

19 AUG 26 1947 for Williams M.R.
(Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/24 1947, at 2:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Les death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH asphyxiation

Due to Aspiration of vomitus

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-24-47 at 4-2 2:30 A. M.
(b) Where did injury occur? 729 W. Fairmount
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Aspiration of vomitus

23. Signature [signature] M.D.
Medical Examiner

Date signed 8-25-47

G51595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/93D

G54595 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 159 Monastary Ave.
(c) Hospital or institution: 20-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 159 Monastary Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) X
If yes, name country

3 (a) FULL NAME Charles D. Israel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Theresa

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 8, 1881

8. AGE: Years	Months	Days	If less than one day
65	9	15 16	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Saleman

11. Industry or business Business

FATHER
12. Name Zasharey Taylor
13. Birthplace Md.

MOTHER
14. Maiden Name Annetta Hained
15. Birthplace Md.

16 (a) Informant Theresa Israel
(b) Address 159 Monastary Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 27/47 (day) (year)

(c) Cemetery or crematory New Catheral
Location Edmonson Avenue

18 (a) Funeral director Lillie Zeiler
(b) Address 403 N Wolfe Street

AUG 26 1947 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 Aug 1947, at 5.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 24 Aug 1947 to 24 Aug 1947 and that I last saw him alive on 24 Aug 1947.

Immediate cause of death	Duration
Coronary Thrombosis acute	8 minutes
Due to Hypertensive Cardio-vascular disease	
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward L. J. Krieg, M.D.
M. D.
Address 604 Stratford Rd Date signed 1947

X

G54596 BCH 31329 BALTIMORE CITY HEALTH DEPARTMENT 56E G54596
CERTIFICATE OF DEATH Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University of Maryland Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 d
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4307 Shamrock Ave
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country .....

3 (a) FULL NAME Michael Mennuccio Jr. Manucci Sr

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 29-1945

8. AGE: Years	Months	Days	If less than one day
1	11	25	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name Michael Manucci
13. Birthplace Balto

MOTHER
14. Maiden Name Catherine Neubert
15. Birthplace Balto

16 (a) Informant Mr Michael Manucci
(b) Address 4307 Shamrock Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 27-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Mr Lehr & Son
(b) Address 300 W Pratt St

AUG 26 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/24 1947, at 6.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/20 1947 to 8/24 1947 and that I last saw h[illegible] alive on 8/24 1947

Immediate cause of death	Duration
Cardio respiratory Collapse	
Due to Cerebral Sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 7/22
Major findings of operation: Cavernous hemangioma, right buttocks
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature H N Taylor M. D.
Address Univ. Hosp. Date signed 8/24/47

G54597

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G54597
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 3
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 452 W Whitridge
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Pacunas

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	MARRIED

6 (b) Name of husband or wife Rose A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1914

8. AGE: Years	Months	Days	If less than one day
33 ~~28~~			hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Wireman - Gas Fit.
11. Industry or business

FATHER
12. Name Charles Pacunas.
13. Birthplace

MOTHER
14. Maiden Name Unknown.
15. Birthplace

16 (a) Informant Mrs. Rose Pacunas
(b) Address 452 Whitridge Ave.

17 (a) B. (b) Date thereof 8-28-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location City

18 (a) Funeral director Wiedefeld & Son
(b) Address Greenmount & 22nd

AUG 26 1947
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/24/47, at 5-45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, ~~suicide~~ ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Electrocution

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-24-47 at 24-4 2:50 P.M.
(b) Where did injury occur? Pt. Covington-G.E. Plant
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Hand touched live wire.

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 8-25-47

VS 191

G54598

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G54598
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16 S. Fremont Ave
(c) Hospital or institution:
18-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 16 S. Fremont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME TRIFKO SIBEL

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widow

6 (b) Name of husband or wife Jacob
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years	Months	Days	If less than one day
82			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Joseph Blaustein
13. Birthplace Russia

MOTHER
14. Maiden Name Lena V
15. Birthplace Russia

16 (a) Informant Samuel Sibel
(b) Address 730 W. Balto St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-26-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Fremont & Hill Rd.

18 (a) Funeral director Jack L. Levin Inc
(b) Address 2100 Eutaw Pl.

19 AUG 26 1947 Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-26-47 19 , at 64. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 19 45 to Aug. 26 1947, and that I last saw h-er alive on Aug. 26 1947

Immediate cause of death	Duration
Edema of lung	1 Da
Due to Chronic Congestive Heart failure	2 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury W J Baylin
23. Signature
Address 2040 Eutaw Date signed 8/26/47

X

Write the causes of death clearly and legibly. Physicians: please write in ink. Typewriting is preferable. Do not abbreviate.

G54599 BCH 8-65076

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 161 C

Registered No. G54599

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 15-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1703 Lormand St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Watcher

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/16/46

8. AGE: Years	Months	Days	If less than one day
	8	8	hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name James Watcher Sr
13. Birthplace Va

MOTHER
14. Maiden Name Defores Burley
15. Birthplace Md

16 (a) Informant James Watcher
(b) Address 1703 Lormand St

17 (a) Burial (b) Date thereof 8/20/47 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location M

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Pennsylvania Ave

19 AUG 26 1947 (b) Huntingtown Williams Md (Date rec'd by registrar) address

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/24 1947, at 2 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl A Royer M.D. Medical Examiner.
Date signed X

C54600 HEALTH DEPARTMENT—CITY OF BALTIMORE C54600

CERTIFICATE OF DEATH 588

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2018 Mc Culloh St. 14-3 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 40 yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Sarah Melissa Evans

If U. S. Veteran specify WAR

(a) Residence: No. 2018 Mc Culloh St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	C	M

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Robert

6. DATE OF BIRTH (month, day, year) 9/15/1892

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54	11	7	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Maryland

FATHER

13. NAME Cromwell Gray

14. BIRTHPLACE (city or town) (State or country) Maryland

MOTHER

15. MAIDEN NAME —

16. BIRTHPLACE (city or town) (State or country) Maryland

17. INFORMANT Robert Evans
(Address) 2018 McCulloh St

18. BURIAL, CREMATION, OR REMOVAL
Place Arbutus Date 8/27/47

19. UNDERTAKER George H. Kelson
(Address) 1303 Eastern Ave

20. Filed AUG 26 1947 21. Huntington Williams

VS 3

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Aug 22, 1947

22. I HEREBY CERTIFY, That I attended deceased from Aug 1 1947 to Aug 21 1947

I last saw her alive on Aug 21 1947 Death is said to have occurred on the date stated above, at 8:45 p. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Acute Endocarditis	7
	1

Other significant conditions of importance:

Rheumatic Fever	Early

Was an operation performed? No Date of

For what disease or injury?

Name of operation

What test confirmed Caused Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) L. D. Vaughan M. D.

2412 Druid Hill Ave

G54601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131A

G54601 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 906 N. Bond St.
(c) Hospital or institution: 7-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 906 N. Bond St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mattie Lowe

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3 1892

8. AGE: Years 55 | Months 5 | Days 10 | If less than one day hr. min.

9. Birthplace Kergeville Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name unknown

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant William Lowe

(b) Address 906 N. Bond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 27 47 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Park

Location Arbutus Md

18 (a) Funeral director Mrs. Robt. A. Elliott Opt.

(b) Address 1129 N. Carolina St

19 (a) Date received by local registrar AUG 26 1947 (b) Registrar Huntington Williamsport Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 1947, at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/13 1947 to 8/23 1947 and that I last saw h.e.r alive on 8/23 1947

Immediate cause of death: Cerebral hemorrhage — Duration: 10 days

Due to: hypertensive cardiovascular disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Rayner Browne, M.D.

Address 1501 E. Madison St Date signed 8/25/47

Rayner Browne

54602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

Registered No. G54602

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 248 Dallas Court
(c) Hospital or institution: 6 5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 248 Dallas ct
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 13, 1892

8. AGE: Years 55 | Months 9 | Days 10 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Andrew Bond

13. Birthplace Cambridge Md

MOTHER 14. Maiden Name Isabella Adams

15. Birthplace Balto. Md.

16 (a) Informant Joseph Green

(b) Address 248 Dallas Ct

17 (a) Burial (b) Date thereof Aug 26 47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem
Location A. A. County Md

18 (a) Funeral director Mrs. Lott A. Ellsworth

(b) Address 1129 N. Caroline St

19 (a) AUG 26 1947 (b) Huntington Williams M.D.
(Date received by Registrar) Registrar

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 1947 at 9:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-11-1947 to 8-23 1947 and that I last saw h[illegible] alive on 8-23 1947.

Immediate cause of death: Bronchio-Pneumonia — Duration: 16 days

Due to: Nephritis Ed — 60 days

Due to: Nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. R. Blake M. D.

Address 1127 N. Eutaw St Date signed 8/27/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 G

G54603 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST.
(c) Hospital or institution: ST. JOSEPH'S HOSP 24-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1031 WILLIAMS ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME KEATING, THOMAS J

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife MARY

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 21 - 1876

8. AGE: Years	Months	Days	If less than one day
C 71	6	4	hr. min.

9. Birthplace IRELAND (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name Timothy Keating
13. Birthplace Ireland

MOTHER
14. Maiden Name ?
15. Birthplace Ireland

16 (a) Informant Mary M. Keating
(b) Address 1031 William St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 27-47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cems.
Location Anne Arundel Co.

18 (a) Funeral director Elizabeth Hartle Fun.
(b) Address 115 E. West St.

19 (a) Date received by Registrar AUG 26 1947 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 1947 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/16 1947 to 8/25 1947 and that I last saw him alive on 8/25 1947

Immediate cause of death	Duration
RESPIRATORY FAILURE	
Due to CACHEXIA	
Due to CARCINOMA, PANCREAS & LIVER METASTASES	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy CA PANCREAS, METAS. LIVER

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry A Porter M.D.
Address St. Joseph's Hosp Date signed 8/25/47

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54604

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

109

Registered No. G54604

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Sorrento Ave.
(c) Hospital or institution: Colonial Consalesing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Sykesville, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Hartley Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Louella Shipley Wilson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4, 1862

8. AGE: Years 85 | Months 7 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore, County
(Town, county, and state)

10. Usual Occupation Plumbing and Heating

11. Industry or business Retired

FATHER
12. Name Benj. F. Wilson
13. Birthplace Penn.

MOTHER
14. Maiden Name Elizabeth Funk
15. Birthplace Baltimore County

16 (a) Informant Mr. William H. Wilson
(b) Address 407 Rock Glen Rd.

17 (a) Burial (b) Date thereof 8 26 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Springfield Presby. Church
Location Sykesville, Md.

18 (a) Funeral director Frederick A. Cole
(b) Address 200 W Lombard St.

19 (a) AUG 26 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 25, 1947, at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1947 to Aug 23 1947 and that I last saw him alive on Aug 20 1947

Immediate cause of death: Congestive Heart Failure — Duration: 4-7 days

Due to: Post Op Pneumonia

Due to: Cerebral

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas Martin, Jr. M. D.
Address 1933 W. Baltimore St. Date signed 8/26/47

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G54605

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47 A

Registered No. G54605

The information should be carefully supplied. Every item should be answered. Where there is no information, write none. Do not abbreviate the causes of death. Physicians: please write clearly and legibly. Underline the cause to which death should be charged statistically. Be sure that the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 136 N. Monastery Ave.
(c) Hospital or institution: 20-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 136 N. Monastery Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Herman Thiemeyer Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Eliza. R. Leonard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1878

8. AGE: Years 68 | Months 11 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Gas & Electeric.

FATHER
12. Name Adolph Thiemeyer
13. Birthplace Germany

MOTHER
14. Maiden Name Carolyn
15. Birthplace Germany

16 (a) Informant Mr. John H. Thiemeyer Jr.
(b) Address 136 N. Monastery Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 30 47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North & Rose Aves.

18 (a) Funeral director Frederick J. Cole
(b) Address 1200 W. Lombard St.

19 (a) AUG 26 1947 (Date rec'd by registrar) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 25 1947, 5.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 7 1947 to Aug 25 1947, and that I last saw him alive on Aug 25 1947.

Immediate cause of death	Duration
Carcinoma of Larynx	1 year
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clarence Engle M.D.
Address 310 W. Baltimore St Date signed 8/26/47

G54606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G54606

Every item of information should be carefully supplied, and the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey St
(c) Hospital or institution: Good Samaritan Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2801 Harlem Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph W. Stonebraker
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	widower

6 (b) Name of husband or wife Kate Anna L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/2/64

8. AGE: Years	Months	Days	If less than one day
82	8	23	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER 12. Name Hargett Stonebraker
13. Birthplace Md.

MOTHER 14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant Mrs Laura L. Rowson
(b) Address 2801 Harlem ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 28/47 (month) (day) (year)
(c) Cemetery or crematory Rose Hill
Location Hagerstown, Md.

18 (a) Funeral director Harry H. Wirtzke
(b) Address 4101 Edmondson Ave

19 (a) Date received AUG 26 1947 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 25, 1947, at 11:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 24 1947, to Aug 25 1947, and that I last saw h[illegible] alive on Aug 25 1947.

Immediate cause of death Toxemia — Duration

Due to Arteriosclerotic Nephritis — Duration

Due to — Duration

Other Conditions Arteriosclerotic H.D. — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stelio Impresciu M. D.
Address 900 W. Lombard Date signed Aug 26 1947
Stelio Impresciu

G54607.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G54607.
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. WRITE WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2529 W. Lanvale St.
(c) Hospital or institution:
16 yrs
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2529 W. Lanvale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel E. Fain

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1855

8. AGE: Years 91 | Months 10 | Days 24 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county and state)

10. Usual Occupation Florist

11. Industry or business Retired

FATHER
12. Name Fain
13. Birthplace Unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Wm. F. Henning
(b) Address 2529 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 27 '47 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location 3801 Frederick Road

18 (a) Funeral director Harry H. Whitelaw
(b) Address 4101 Edmondson Ave.

19 AUG 26 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 156

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 24 47, 19, at 9 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 24 19 42 to Aug 24 19 47, and that I last saw h alive on Aug 22 19 47.

Immediate cause of death	Duration
Arteriosclerotic Cerebro-Vascular Disease	7
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert J. Stonebraker M.D. M. D.
Address 302 Eldonton Rd. Date signed 8/26/47

G54608 CWK-113257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓46 G

Registered No. G54608

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 12-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 428 E. 20th Street (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MARY C. BRYAN

3 (b) If veteran, name war: ---
3 (c) Social Security Account No.: ----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife: William C. Bryan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30-1879

8. AGE: Years	Months	Days	If less than one day
67	10	25	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name John J. Gahagan
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Gortland
15. Birthplace Ireland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/27/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Evans & Son, Inc.
(b) Address 118 W. Mt. Royal Ave.

19 (a) (Registrar) (b) Huntington Williams, M.D.

AUG 26 1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1947, at 1:03 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 23 1947 to Aug. 25 1947, and that I last saw her alive on Aug. 25 1947.

Immediate cause of death ? Ca of Stomach Head of Pancreas — Duration 5

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert A. Fauber M. D.
Address Balto. City Hosp. Date signed 8-25-47

X

G54609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G54609

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians; please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 Park Heights Ave
(c) Hospital or institution:— Mt Sinai Home 27-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 606 to Hanover St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie Zaid

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Jacob
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 71 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Mordegai
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Charley Zaid
(b) Address 606 to Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-27-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Sharon Cem
Location Springfield Pa

18 (a) Funeral director Jack Lewis Inc
(b) Address 700 Eutaw Place

19 AUG 26 1947 (Date rec'd by Local Reg.) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-25-1947, at 12 P 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/15 1947 to 8/25 1947 and that I last saw h alive on 8/24 1947.

Immediate cause of death Edema
Myocarditis

Due to

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 8/26/47

VS 150

93D

G54610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

Registered No. G54610

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3241 Cliftmont Ave
(c) Hospital or institution: 26-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3241 Cliftmont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna B. Behme

3 (b) If veteran, name war

3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widowed

6 (b) Name of husband or wife John L. Behme

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7-1856

8. AGE: Years	Months	Days	If less than one day
90 89	8	16	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business —

MOTHER / FATHER

12. Name Behme

13. Birthplace Germany

14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant Elizabeth Rapp

(b) Address 3241 Cliftmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/27/47 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Taylor Ave

18 (a) Funeral director Wm. J. Connelly

(b) Address 48 Eastern Ave

19 AUG 26 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-23- 1947, at 8:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-23- 1947 to 19 , and that I last saw her alive on 8-23-1947

Immediate cause of death	Duration
Arteriosclerotic Cardio vascular Disease	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nelson C. Rapp M. D.

Address 2117 Belair Rd Date signed

For Office Statistician by Howard J. Andrews, M.D. 8-26-47

G54611

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 523

Registered No. G54611

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4400 Springwood
(c) Hospital or institution: 26-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4400 Springwood
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Behrmann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Ethel (Bowman)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-9-1885

8. AGE: Years	Months	Days	If less than one day
62	45	16	hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Otto Behrmann
13. Birthplace Md.

MOTHER
14. Maiden Name Rosina Faber
15. Birthplace Md

16 (a) Informant Mrs Ethel Behrmann
(b) Address 4400 Springwood

17 (a) Burial (b) Date thereof 8-28-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto Md

18 (a) Funeral director Leonard J Funk
(b) Address 5005 Harford Rd

AUG 26 1947 (b) Huntington Williams, Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-25 1947 at 9:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1 1943, to 8/25 1947, and that I last saw him alive on 8/22/1947.

Immediate cause of death CANCER of URINARY BLADDER — Duration 4 yrs +

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: CANCER of URINARY BLADDER

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John W Machen M. D.
Address 6331 Belair Rd Date signed 8/25/47

G54612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G54612 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Washington D.C. (If outside city or town limits, write RURAL and give town)
(d) Street No. 28 N. Street S.E. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Regina Middleton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe-male	Colored	married

6 (b) Name of husband or wife Walter.
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) 8-27-90

8. AGE: Years	Months	Days	If less than one day
56	11	29	hr. min.

9. Birthplace md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Samuel Sewell
13. Birthplace md

MOTHER 14. Maiden Name Louise Jackson
15. Birthplace md

16 (a) Informant Reynolds
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/26/47 (month) (day) (year)
(c) Cemetery or crematory
Location Washington D C

18 (a) Funeral director Bowie & Matthews
(b) Address 614-4th St. S.W. Washington D.C. (Huntington Northwest, Md.)

AUG 26 1947 (Date received by Registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 26 1947 at 12 17 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15 1947, to Aug. 26 1947, and that I last saw h[illegible] alive on Aug. 26 1947.

Cause of death	Duration
Immediate cause of death: cardiac failure	4 hours
Due to: hypertensive arteriosclerotic heart disease	? years
Due to:	
Other Conditions: multiple neurofibromatosis with sarcomatous degeneration of right thigh (Include pregnancy within 3 months of death)	50 years

Date of operation Aug. 25, 1947
Major findings of operation: sarcoma of right thigh
of autopsy: cardiac dilatation

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dale G. Foster
Address Johns Hopkins Hospital Date signed M. D. 8/26/47

X

G54613

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 91A

G54613
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 729 N. Spring St.
(c) Hospital or institution: 10-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 729 N. Spring St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Ringgold

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years 40 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Presser

11. Industry or business

FATHER
12. Name William Ringold
13. Birthplace R. I. Co Md

MOTHER
14. Maiden Name Elizabeth Weeks
15. Birthplace G. O. Co Md

16 (a) Informant Isabella Ringgold
(b) Address 729 N. Spring St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 29, 1947 (month) (day) (year)
(c) Cemetery or crematory Baltimore National Cem.
Location Baltimore Md

18 (a) Funeral director Chas. O. Wilson
(b) Address 1000 Blanchard Ave

AUG 26 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-25- 1947 at 2 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Subacute bacterial endocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Kruger M.D. (Medical Examiner)
Date signed 8-26-47

VS 151

Please write the causes of death clearly and legibly. Use typewriter if convenient. Do not use any abbreviations. Any physician willfully signing a false certificate is guilty of a misdemeanor and subject to a fine of not more than $500.00 or imprisonment for not more than one year, or both.

write the causes of death clearly and legibly. Physicians: please write plainly. Necessary supplies.

614

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 113

G54614
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital 5-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1261 E. Fayette Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James EDWARD BOBBITH MITCHELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18, 1933.

8. AGE: Years 14 | Months 4 | Days 5 | If less than one day hr. min.

9. Birthplace Nashville, N.C.
(Town, county, and state)

10. Usual Occupation School

11. Industry or business

FATHER
12. Name Lutha Bobbitt
13. Birthplace N.C.

MOTHER
14. Maiden Name Semie Mitchell
15. Birthplace N.C.

16 (a) Informant Semie Mitchell
(b) Address 1261 E.Fayette St.

17 (a) Burial (b) Date thereof Aug 27, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Brooklyn Md

18 (a) Funeral director Chas D. Wilson
(b) Address 1020 Bibbitty Ave

19 (a) [illegible] (b) Huntington Hill, Md.
(Filed by Registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23, 1947, at 7:P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 8-23-47 at 6:30 P. M.
(b) Where did injury occur? Anne Arundel Grave Sand Co. Brooklyn, Maryland
(c) Did injury occur at home, on farm, industrial place, in public place? River While at work? no
(d) Means of injury Drowning

23. Signature Earl L. Pyles M.D.
Medical Examiner.
Date signed 8-25-47

G54615

BALTIMORE CITY HEALTH DEPARTMENT

CWK- 111865

CERTIFICATE OF DEATH 193D

G54615 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 6-✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Month
(e) Length of stay in Baltimore (yrs., mos., or days) 18 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 24 N. Bond Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: James Clark

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Annie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26-1897

8. AGE: Years 50 | Months 2 | Days 29 | If less than one day ... hr. ... min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Elijah Clark (D)
13. Birthplace West Virginia

MOTHER
14. Maiden Name Miley Clark
15. Birthplace North Carolina

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 29 1947 (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director Harry G. Wilson
(b) Address 1700 Bentley ave

19 AUG 26 1947 (Date received by Registrar) (b) Registered No.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 19 47, at 2:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 2- 19 47, to Aug. 25 19 47 and that I last saw him alive on Aug. 25 1947.

Immediate cause of death	Duration
Pulmonary Edema	24 hrs.
Due to Myocardial degeneration, recent angina and psoriasis	7 weeks
Due to Arteriosclerotic Heart Disease.	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature Lawrence Lee Jr. M. D.
Address Balt. City Hosps. Date signed 8-25-47

IMPORTANT. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G54616

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 lbs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTO.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 105 Midhurst Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Rue Willard Barnaby III

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 11, 1932

8. AGE: Years	Months	Days	If less than one day
15	0	14	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name Louis R.W. Barnaby II
13. Birthplace Olney, Md.

MOTHER
14. Maiden Name Margaret Adam
15. Birthplace Gabriel, Md.

16 (a) Informant Louis R.W. Barnaby II
(b) Address 105 Midhurst Rd

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8-26-47 (month) (day) (year)
(c) Cemetery or crematory Bethesda, Md.
Location

18 (a) Funeral director Wm. R. Pumphrey.
(b) Address Bethesda Md.

19 Date 8 26 1947 registered

Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1947, at 1:50 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fractured skull
Compound fracture of right tibia & fibula
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 53-00
(a) Date of injury 8-25-47 at 3:40 P M.
(b) Where did injury occur? Bellona Ave Baltimore
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? no
(d) Means of injury Struck by auto

23. Signature [signature] M.D.
Medical Examiner
Date signed 8-26-47

Please write the causes of death clearly and legibly. Physicians: please write explanatory supplements.

C54617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. C54617

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 E. Preston Street
(c) Hospital or Institution: 9-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2025 E. Preston Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH ROEDER

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1867

8. AGE: Years	Months	Days	If less than one day
79	11	13	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name Henry Warner
13. Birthplace Maryland

MOTHER
14. Maiden Name Theresa (Unknown)
15. Birthplace Maryland

16 (a) Informant Mrs. Elizabeth Salom
(b) Address 2025 E. Preston Street

17 (a) Burial (b) Date thereof Aug. 25, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) AUG 26 1947 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1947, at 3:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from January 8 1947, to August 25 1947, and that I last saw her alive on August 25 1947.

Immediate cause of death	Duration
Toxic absorption	3 days
Due to Carcinoma of breast	5 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Michael J. Dausch M. D.
Address 1 W. American Ave. Date signed 8/26/47

X

G54618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G54618

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Salem City Box 12
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Csekey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Male | 5 Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-22-82

8. AGE: Years 65 | Months 7 | Days 7 | If less than one day ___ hr. ___ min.

9. Birthplace Hungary (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Stephen Csekey
13. Birthplace Hungary

MOTHER 14. Maiden Name Barbara Myles
15. Birthplace Hungary

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Interment (b) Date thereof 8/26/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn
Location Louisa — Virginia

18 (a) Funeral director Wm Hook Jr
(b) Address 217 St Paul St

19 (a) AUG 26 1947 (b) Huntington Williams, Md.
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-25-1947, at ~~12~~ M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-29 1947 to 8-25 1947, and that I last saw ~~him~~ alive on 8-25 1947.

Immediate cause of death: Pneumonia R. lung & LLL — Duration: 4 days
Due to: Chronic Lymphoid Leukemia — 9 mos
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: Not yet reported

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas E. Van Metre JR M. D.
Address John Hopkins Hosp Date signed
Baltimore, Md

G54619

BALTIMORE CITY HEALTH DEPARTMENT

BC# 687004 CERTIFICATE OF DEATH V 159

G54619 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Sparrows Point -19,-Rural (If outside city or town limits, write RURAL and give town)
(d) Street No. 7321 Geise Ave.,Jones Creek (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pender

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M.

5. Color or race: W.

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day: 1 hr. V min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Franklin Pender
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Eva Frances Weber
15. Birthplace Sparrows Point Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

(Date rec'd by Registrar)

University Medical School AUG 26 1947
Commissioner of Health

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-25-47 19 , at 7:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-21-47 to 8-25-1947, and that I last saw him alive on 8-21-1947.

Immediate cause of death — Duration

Respiratory failure

Due to

Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William F. Bauer M. D.

Address Bon Secours Hosp. Date signed 8-25-47

VS 150

G54620 City Dispensary B-85974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161 C

Registered No. G54620

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 615 N. Stricker
(c) Hospital or institution: University Hosp. 16 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 15 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 615 N. Stricker St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Maurice Brown

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex male | 5. Color or race colored | 6 (a) Single, married, widowed, or divorced. single (Never)

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/8/47

8. AGE: Years 0 | Months 0 | Days 15/3 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name Lena Brown
15. Birthplace N.C.

16 (a) Informant
(b) Address

17 (a) ..... (b) Date thereof .....
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School AUG 26 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) AUG 26 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/21 1947 at 4:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/15 1947 to 8/21 1947 and that I last saw h.i.m. alive on 8/21 1947.

Immediate cause of death Uremia

Due to Erythroblastosis Foetalis

Due to

Other Conditions Unilateral exophthalmos Status Lymphaticus tendencies
(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury

23. Signature John Bruce Pratt, Jr. M. D.

Address Univ. Hosp. Date signed 8/21/47

X

IMPORTANT. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 930

G51621
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Milton Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9

(e) Length of stay in Baltimore (yrs., mos., or days) 7 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 Milton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Laura E Broadwater

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	W	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19 1872

8. AGE: Years	Months	Days	If less than one day
75	3	7	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Noah Garlitz
13. Birthplace Maryland

MOTHER
14. Maiden Name Martha McKinzie
15. Birthplace Maryland

16 (a) Informant Mrs Daniel Miller
(b) Address 1400 Milton Ave.

17 (a) Burial (b) Date thereof Aug. 26/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Avilton
Location Avilton, Maryland

18 (a) Funeral director John O Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) Aug 27 1947 (b) Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 1947, at 5:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 1947 to Aug 26 1947, and that I last saw her alive on Aug 26 1947.

Immediate cause of death Acute Cardiac Failure

Due to Arteriosclerotic Cardio-Vascular Disease & Hypertension

Due to

Other Conditions Cerebral Hemorrhage resulting in Hemiplegia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

Duration
2 Yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H B Stevens M.D.

Address 3400 Erdman Ave. Date signed 8/25/47

V$ 150

correct age is especially important. Physicians: please write the

C5 1622

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G54622 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 130 W. Lexington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) - 1 - 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 757 Poplar Grove
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matilda Heinzer
3 (b) If veteran, name war
3 (c) Social Security Account No. NONE

4. Sex F.
5. Color or race W
6 (a) ~~Single~~, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife Lewis W.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 27-18
8. AGE: Years 81 Months 4 Days 28 If less than one day hr. min.
9. Birthplace Baltimore - Md.
(Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Frederand Gueske
13. Birthplace Germany

MOTHER
14. Maiden Name Bertha E. Wiekmann
15. Birthplace Germany

16 (a) Informant Mrs. Lola Stevens
(b) Address 5707 Harford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-27-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk -
Location Baltimore - Md

18 (a) Funeral director William Cook Inc
(b) Address 1717 St. Paul St -

AUG 27 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 1947, at 425 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 23 1947 to Aug 24 1947, and that I last saw h[illegible] alive on Aug 24 1947

Immediate cause of death	Duration
(a) Broncho pneumonia	2 wks.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Helen Shipman M.D.
Address 910 W. Lombard Date signed Aug 26 1947

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83A

G54623
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1219 Light St.
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 955 Jeffery St (Rural route location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Lohr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Marshall Lohr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 27, 1898

8. AGE: Years 49 | Months 3 | Days 29 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Samuel Kendall
13. Birthplace Maryland

MOTHER
14. Maiden Name Adda Burns
15. Birthplace Maryland

16 (a) Informant Wolford Funeral Home
(b) Address Cumberland, Md.

17 (a) Removal (b) Date thereof 8-27-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cumberland
Location Cumberland, Md.

18 (a) Funeral director Wm. Cook Inc.
(b) Address 1217 St. Paul St.

AUG 27 1947 Huntington Williams, M.D.
(Date Rec'd by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 Aug 1947 at 3:15 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Subarachnoid hemorrhage, Spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner.
Date signed 26 Aug 47

X

G54621

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 95B

Registered No. G54621

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton + Wilkens ave
(c) Hospital or institution:
St. Agnes Hospital · 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 201 Mc Comas St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Kathleen Stevenson

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: late George H. Stevenson

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Jan 2 - 1903

8. AGE: Years 44 | Months 7 | Days 23 | If less than one day ____ hr. ____ min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name Charles Willey

13. Birthplace Va.

MOTHER — 14. Maiden Name Louella Willey deed

15. Birthplace Va

16 (a) Informant Anna K. Stebeley

(b) Address 201 McComas

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 27, 1947 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location A. C. 150

18 (a) Funeral director A. Howard Evans

(b) Address 1460 N. Charles St.

19 (a) Date rec'd by registrar AUG 27 1947 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-25 1947 at 10 40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/25 1947 to 8/25 1947 and that I last saw h[illegible] alive on 8/25 1947.

Immediate cause of death Acute cardiac failure with pulmonary edema — Duration: 1 hrs.

Due to Rheumatic heart disease — Duration: ? yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Rheumatic heart disease

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert J. Levitan

Address St. Agnes Hosp. Date signed M/D. 8/26/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The ... Every item of information should be carefully supplied. ... PRINTING INK.

G54625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95C

G54625
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 910 E. Preston St.
(c) Hospital or institution:

9-9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 910 E. Preston St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Filomena Carletti

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife XXXX late Luigi
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8 1871

8. AGE: Years	Months	Days	If less than one day
76	6	17	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Felice Monaco
13. Birthplace Italy

MOTHER
14. Maiden Name Concetta ?
15. Birthplace Italy

16 (a) Informant Lena Luciano (Daughter)
(b) Address 910 E. Preston St.

17 (a) Burial (b) Date thereof Aug. 28 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Wells Hoel
(b) Address 52 N. Morley St.

19 (a) (b)
AUG 27 1947 (Date registered) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-25 1947, at 11.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/23 1947 to 8/25 1947, and that I last saw h alive on 8/25 1947.

Immediate cause of death Acute Cardiac dilat

Due to

Due to Senility

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature
Address 440 E Balto Date signed 8/26/47 M. D.

54626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

G54626 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 246 S. Clinton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Mancini

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14, 1931

8. AGE: Years	Months	Days	If less than one day
15	10	11	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation School-boy

11. Industry or business

FATHER
12. Name James V. Mancini
13. Birthplace Italy

MOTHER
14. Maiden Name Sylvia Lamartina
15. Birthplace Balto. Md.

16 (a) Informant James V. Mancini
(b) Address 246 S. Clinton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/47 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Rd. Balto.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

AUG 27 1947 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1947, at 4:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH
Fractured skull
Ruptured liver and spleen
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 26-9
(a) Date of injury 8-25-47 at 4:10 P.M.
(b) Where did injury occur? Foster Ave & Grundy St.
(c) Did injury occur at home, on farm, industrial place, is public place? Public Place While at work? yes
(d) Means of injury Fell from moving truck

23. Signature [signature] M.D.
Medical Examiner.
Date signed 8-26-47

VS 181

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54627

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered No. G54627

Every item of information should be carefully supplied. Typewriter, with UNFADING INK. Every death must be registered, and a burial permit obtained, before a body can be removed for burial. Physicians: please write the causes of death clearly and legibly. Be sure that the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3911 Cold Spring Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 3911 Cold Spring Lane (If rural give location)
(e) Citizen of foreign country? W (Yes or No)
If yes, name country

3 (a) FULL NAME Esther Rochel Herman

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late Jacob Moses
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years	Months	Days	If less than one day
82			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Hirsch Harris
13. Birthplace Russia

MOTHER
14. Maiden Name Unkown
15. Birthplace Russia

16 (a) Informant Ralph Herman
(b) Address 3911 Cold Spring Lane

17 (a) Burial (b) Date thereof Aug 27, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cemetery
Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

(a) Date received AUG 27 1947 (b) Registrar for Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION 1.10

20. DATE OF DEATH August 26 1947, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/25 1947, to 8/26 1947 and that I last saw h[illegible] alive on 8/26 1947.

Immediate cause of death	Duration
Acute Cerebral Hemorrhage	
Due to Ch Nephritis	
Due to Acute Cardiac Collapse	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Tomatsen M.D.
Address 733 Augusta St Date signed 8/26

G54628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

930

Registered No. G54628

Every item of information should be carefully supplied. Use black ink, with UNFADING INK. Entries must be made clearly in permanent record; please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5105 Palmer Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Jacobson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3, 1896

8. AGE: Years	Months	Days	If less than one day
51	2	23	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business House Wife

FATHER
12. Name Philip Friedel
13. Birthplace Russia

MOTHER
14. Maiden Name Rose Franklin
15. Birthplace Russia

16 (a) Informant Philip Jacobson
(b) Address 5105 Palmer Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 28, 1947 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem
Location 3600 E Baltimore St

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

AUG 27 1947 (Date rec'd by registrar) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 1947 at 1.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 25 1947 to Aug 26 1947 and that I last saw h.. alive on Aug 26 1947

Immediate cause of death Cerebral Hemmorhage. — Duration 8 hrs.

Due to Hypertension C.V. Disease. — 1 yr. +

Due to

Other Conditions Chronic Arthritis.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Cerebral Hemmorhage.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Oscar Levinson M. D.
Address Sinai Hospital Date signed 8/26/47

X

G54629

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G54629 MR

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 435 Bloom St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 435 Bloom St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clarke L. Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary F. Hammond Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25-1879

8. AGE: Years 67 | Months 8 | Days 0 | If less than one day hr. min.

9. Birthplace Jacksonville Fla (Town, county, and state)

10. Usual Occupation Lawyer

11. Industry or business

FATHER
12. Name Avery Smith
13. Birthplace Fla

MOTHER
14. Maiden Name Adele Dillon
15. Birthplace Fla

16 (a) Informant Anna Smith Read (daughter)
(b) Address 2404 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 28 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Meml. Park
Location Balto. Co. Md.

18 (a) Funeral director John M. Johnson
(b) Address 1700 Druid Hill Ave

AUG 27 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/25 1947, at 7:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. L. Schmidt M.D.
Medical Examiner.
Date signed 8/25/47

Please write the causes of death clearly and legibly. Physicians: please write in especially important. Use

654630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

947

Registered No. 654630

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 mos
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 611 Asquith St (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Raphael Glickman

3 (b) If veteran, name war..... (c) Social Security Account No.....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years	Months	Days	If less than one day
43	5		..... hr. ..... min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Presser
11. Industry or business.....

FATHER
12. Name Philip
13. Birthplace Russia

MOTHER
14. Maiden Name Bessie
15. Birthplace Russia

16 (a) Informant Samuel Fine
(b) Address 1526 No Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-27-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phila Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2160 Eutaw Place

19 (a) AUG 27 1947 (Date rec'd by reg'r) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1947, at 8:15 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH.....
Coronary thrombosis
Acute edema of lungs
Due to.....
Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature George G. Merrill M.D. (Medical Examiner.)
Date signed 8-26-47

Please write the causes of death clearly and legibly. Please give age in especially important. Physicians: please write

54631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 127a

Registered No. G54631

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly, IN INDELIBLE PENCIL, WITH UNFADING INK

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Charles & West St
(c) Hospital or institution:
South Baltimore Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3208 Mc Ellerdy
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Raymond Hamill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	Married

6 (b) Name of husband or wife Anna Urban Hamill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 28 1889

8. AGE: Years	Months	Days	If less than one day
57	9	27	hr. min.

9. Birthplace Baltimore (city or county, and state)
10. Usual Occupation Fireman Balto City Fire Dept
11. Industry or business

FATHER
12. Name Peter Hamill
13. Birthplace Md

MOTHER
14. Maiden Name Anna ?
15. Birthplace Md

16 (a) Informant Mrs Anna Hamill
(b) Address 3208 McEllerdy St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 28 /47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

AUG 27 1947 Huntington Williams M.D.
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6-25 1947; at 5.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-13 1947, to 6-25 1947, and that I last saw him alive on 6-25 1947

Immediate cause of death Generalized peritonitis — Duration 3 days

Due to Evisceration and Bile extravasation — Duration 6 hrs

Due to Rupture of Gall bladder — Duration

Other Conditions Empyema of Gall bladder

(Include pregnancy within 3 months of death)

Date of operation 6-13-47

Major findings of operation: Rupture of gall-bladder

of autopsy: Not Done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. A. Hilden M.D.
Address X Date signed

BALTIMORE CITY HEALTH DEPARTMENT ✓ G54632
Registered No.

CERTIFICATE OF DEATH

54632 BC# 85014 157E

Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6738 E. Pratt St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eleanor Joanne Gilpin

3 (b) If veteran, name war	3 (c) Social Security Account No.

Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-26-47

8. AGE: Years	Months	Days	If less than one day
	1	0	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Douglas Gilpin, Sr
13. Birthplace Md.

MOTHER
14. Maiden Name Carolyne Booker
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 27-47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location City

18 (a) Funeral director Wenzel Funeral Home
(b) Address 200 S. Arlington Ave.

19 (a) AUG 27 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 1947, at 10:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 24 1947, to Aug 26 1947, and that I last saw h[illegible] alive on Aug 26th 47

Immediate cause of death	Duration
Heart Failure	
Due to Congenital Heart Disease	Life
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Philip Brown M.D.
Address Johns Hopkins Hosp Date signed 8-26-47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

5633 — G54633 Registered No.

Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important. PRINT WITH PEN AND INK. NO PENCIL. NO ERASURES. NO OVERWRITING.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3117 Woodhome Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3117 Woodhome Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Captain Alonzo Jones

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Theodosia Jones

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20 1858

8. AGE: Years 89 | Months 3 | Days 6 | If less than one day hr. min.

9. Birthplace Somerset County - Md (Town, county, and state)

10. Usual Occupation Sea Captain

11. Industry or business

FATHER
12. Name Elijah Jones
13. Birthplace Somerset County, Md

MOTHER
14. Maiden Name Francis Vetra
15. Birthplace Somerset County - Md

16 (a) Informant Mrs. Blanch McDorman
(b) Address 3117 Woodhome Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/47 (month) (day) (year)
(c) Cemetery or crematory Lorayne Cemetery
Location Woodlawn, Md

18 (a) Funeral director Howard N. Blight, Jr.
(b) Address 6009 Harford Road

(c) Date rec'd by registrar AUG 27 1947 (d) Signature of registrar Hamilton for Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 August 1947 at 3:20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1946 to Aug. 1947 and that I last saw him alive on 25 Aug. 1947

	Duration
Immediate cause of death Heart Failure	1 day
Due to Arteriosclerotic Cardio-vascular disease	10 years
Due to Senility	
Other Conditions Diabetes, Chronic Nephritis, Bilateral Inguinal Hernia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Tom M. Zimmerman M. D.

Address 2858 Harford Rd Date signed 26 Aug. 47

931

654634

BALTIMORE CITY HEALTH DEPARTMENT ✓

CERTIFICATE OF DEATH 46 E

Registered No. 654634

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution:
Mercy Hospital 4th
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Mercy Hospital
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Mary Helen Ryan R.S.M.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 25, 1881

8. AGE: Years	Months	Days	If less than one day
66	2	1	hr. min.

9. Birthplace W. Virginia (Town, county, and state)

10. Usual Occupation Religious Nurse

11. Industry or business

FATHER 12. Name John Ryan
13. Birthplace Ireland

MOTHER 14. Maiden Name Delia Noone
15. Birthplace Ireland

16 (a) Informant Mother Provincial
(b) Address Mt. Washington, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/29/47 (month) (day) (year)
(c) Cemetery or crematory Mt. St. Agnes Conv. Cem.
Location Mt. Washington

18 (a) Funeral director H. H. Mears and Son
(b) Address 805 N. Calvert St.

AUG 27 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1947, at 12 in A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 17 1947, to Aug. 26 1947, and that I last saw her alive on Aug. 26 1947

Immediate cause of death Cachexia — Duration 2 mos.

Due to Carcinoma of Colon with Generalized Metastasis — Duration 1 yr.

Due to

Other Conditions Coronary Insufficiency

(Include pregnancy within 3 months of death)

Date of operation May 5 1947

Major findings of operation: Ca of Colon Generalized Metastasis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William F. Schnitker M. D.

Address Mercy Date signed 8-26-47

VS 150

G54635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G54635

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 935 W. Fayette St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 935 W. Fayette St (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Edna Corbin Boone

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: colored

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22, 1931

8. AGE: Years 16 | Months 1 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Public school

11. Industry or business

FATHER
12. Name William Boone
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Catherine Corbin
15. Birthplace Baltimore, Md.

16 (a) Informant Catherine Corbin Beckwith
(b) Address 935 W. Fayette

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/47 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial Pk.
Location Balto County, Md

18 (a) Funeral director Chas. L. Corpen
(b) Address 510 N. Carrollton Ave

AUG 27 1947 (b) Huntington Williams, M.D.
(Date rec'd by Reg. (Signature of Registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 8.25.47 19 at 8 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8.11.47 19 to 8.25.47 19, and that I last saw her alive on 8.24.47 19

Immediate cause of death: Pulmonary Tuberculosis — Duration 7 mo. 14 da.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James M. Fair M. D.
Address 406 N. Carrollton Date signed 8.25.47

G54636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 930

Registered No. G54636

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNIVERSITY HOSP
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 608 Burgundy Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Luther HINTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: MALE | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-17-1885

8. AGE: Years 62 | Months 0 | Days 8 | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Jennie Duffin
15. Birthplace N. C.

16 (a) Informant Jesse M. Toney
(b) Address 610 Burgundy St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location B. A. B. Md

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery St

19 (a) AUG 27 1947 (Date received by Registrar) (b) Huntington Williams (Registrar)

VS 151

MEDICAL CERTIFICATION 25

20. DATE OF DEATH August 25, 1947 at 1 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arterioselerotic cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 8/26/47 X

Physicians: please write the causes of death clearly and legibly. The cause primarily responsible, or which started the morbid process resulting in death, should be stated last. Indefinite or unusual terms, abbreviations, and words not commonly understood should be avoided. Do not state the mode of dying, such as heart failure, asphyxia, anemia, or uremia.

G54637

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 32

G54637 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 811 N. Mount St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susie Newsom

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-3-93

8. AGE: Years	Months	Days	If less than one day
54	7	22	hr. min.

9. Birthplace Ga. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Clay Wayman
13. Birthplace Ga.

MOTHER
14. Maiden Name Anna Hillman
15. Birthplace Ga.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 28 47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location B. Co Md
18 (a) Funeral director Isaiah L. Brown Son
(b) Address 1084 Montgomery St
19 (a) Date received by registrar AUG 27 1947 (b) Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1947, at 8 20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 22 1947 to Aug 25 1947 and that I last saw h alive on Aug 25 1947

Immediate cause of death	Duration
Coronary Occlusion	
Due to Myocardial Infarction	2 days
Due to Hypertension and Cardiac Decompensation	Late
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature M. D.
Address Johns Hopkins Hosp Date signed

G54638

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12

G54638 Registered No.

Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Balto Gen'l. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 348 Montrose Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Klapka ✓

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-07-3905

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife. Bertha C. Albrecht
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 28, 1903

8. AGE: Years	Months	Days	If less than one day
43	10	28	hr. min.

9. Birthplace Czechoslovakia
(Town, county, and state)
10. Usual Occupation Steel Cutter
11. Industry or business B.S.Co.

FATHER
12. Name Ferdenand
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Anna Landa
15. Birthplace " "

16 (a) Informant Bertha Klapka
(b) Address 348 Montrose Ave.

17 (a) Burial (b) Date thereof 8/ 29/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway

1947 Tennington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 1947, at 5 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 25 1947 to Aug 26 1947 and that I last saw h[illegible] alive on Aug 26 1947.

Immediate cause of death	Duration
Respiratory failure	1 day
Due to Tetanus (probably)	2 days
Due to ?	
Other Conditions Lobar pneumonia & Ulcer	years

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Lobar pneume, & Ulcer

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Mercy Balto Gen'l. Hosp. Date signed Aug 27th 47

G54639

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 4B

G54639 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John Sts.
(c) Hospital or institution: Hospital for the Women of Md. 9-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore - 18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1545 Homestead St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Cecelia Estelle Bevans
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Charles P Bevans
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) May 29, 1884

8. AGE: Years 63 | Months 2 | Days 27 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Charles F. Wallslager
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth King
15. Birthplace Baltimore, Md.

16 (a) Informant Deceased-L.A. Bevans
(b) Address 1545 Homestead St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 28/47 (month) (day) (year)
(c) Cemetery or crematory Carlton
Location Baltimore, Md.

18 (a) Funeral director F. D. Heppert & Son
(b) Address 300 E. Lanvale St.

19 (a) Date received by registrar AUG 27 1947 (b) Registrar's signature Wallace Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1947, at 2 05 M

21. I certify that death occurred on the date above stated; that I attended deceased from August 9 1947 to August 25 1947, and that I last saw her alive on August 25 1947

Immediate cause of death	Duration
Respiratory failure	
Due to Metastatic Carcinoma of the lung	
Due to Carcinoma of the body of the uterus	10 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Not performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank H. Logan M. D.
Address Hospital for Women of Md. Date signed 8-26-47

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54640

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92d

G54640 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1920 W. Fayette St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1920 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Wilhelm Wehrenberg
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Kunigunda -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 13 - 1868

8. AGE: Years	Months	Days	If less than one day
79	7	11	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Shoe Maker
11. Industry or business Own business - Retired

FATHER
12. Name Fritz Wehrenberg
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina Butts
15. Birthplace Germany

16 (a) Informant Kunigunda Wehrenberg
(b) Address 1920 W. Fayette St.

17 (a) Burial (b) Date thereof 27 - Aug. 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Paul's
Location Catonsville - Md.

18 (a) Funeral director F. B. Wippert & Son
(b) Address 1300 Eutaw Place

19 (a) (Signature) by registrar (b) Washington Williams Registrar

27 1947

S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 - 1947 at 10:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1947 to Aug 24 1947. and that I last saw h. alive on Aug 24 1947

Immediate cause of death	Duration
Arteriosclerotic C.V. disease	5 yr
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature C. P. Funkenstein
Address 1926 W. Balto St. Date signed 8/26/47

G54641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 942

G54641 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3075 Fayette St.
(c) Hospital or institution:
Don Secours Hosp. 2d
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2502 [redacted] St.
(If rural give location)
(e) Citizen of foreign country? Hollins (Yes or No)
If yes, name country

3 (a) FULL NAME
Dr. Joseph George Countess

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-01-0917

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31st 1907

8. AGE: Years 38 | Months 2 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Surgical Nurse

11. Industry or business U. S. Navy

FATHER
12. Name Joseph F. Countess
13. Birthplace Md

MOTHER
14. Maiden Name Emma Butler
15. Birthplace Md

16 (a) Informant Mrs Henry Hess
(b) Address 2502 Hollins St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 28/42 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director F. D. Wagner & Son
(b) Address 200 Eastern Ave

19 (a) (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 116

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1942, at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 25 1942 to 19, and that I last saw him alive on Aug. 25 1942.

Immediate cause of death Coronary occlusion

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul C. Manning M. D.
Address Don Secours Hosp. Date signed 8/25/42

This item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54642

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

168

G54642 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 900 S. Kenwood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AGNES RIEMER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
53 2	-		hr. min.

9. Birthplace Unknown
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs Oliphant
(b) Address 237 S. Highland, Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-27-47 (month) (day) (year)
(c) Cemetery or crematory Swartz
Location Old Donell, St.

18 (a) Funeral director Lilly & Zeiler, Inc.
(b) Address 403 S. Wolfe, St.

AUG 27 1947
(Date rec'd by registrar) (b) Huntington Hilligoss M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25, 1947, at 4.10 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation
due to strangulation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-25-47 at A M.
(b) Where did injury occur? 900 S. Kenwood Ave
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Manual Strangulation

23. Signature Carl L. Knight M.D.
Medical Examiner

Date signed 8-25-47

Please write the causes of death clearly and legibly. Physicians: please

G54643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 93d

G54643
Registered No.

Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Md.
(c) Hospital or institution:
426 E. Randall St. 24
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 426 E. Randall St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Spurrier

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband ~~of wife~~ Charles G. Spurrier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 4, 1868

8. AGE: Years	Months	Days	If less than one day
79	0	22	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Clemm
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Laura Mooney
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Myrtle M. Carman
(b) Address 426 E. Randall St.

17 (a) Burial (b) Date thereof 8/29/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Pk. Cem.
Location Balto. Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

19 (a) Thurlington Williams, M.D.
(Signature of registrar) Registrar
AUG 27 1947

150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 26 1947, at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1 1945 to 8-26 1947, and that I last saw h[illegible] alive on 8-25 1947.

Immediate cause of death	Duration
Chronic Myocardial Degeneration	2 yrs.
Due to Arteriosclerosis	2 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. E. Sollod M. D.
Address 207 Fort Ave. Date signed 8-28-47

X

G54644

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G54644 Registered No. 932

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital D.o.a.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(b) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1726 Barnes Streeet
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Parker

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-12-2987

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Laura (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace Calvert County Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name ?
13. Birthplace Md

MOTHER
14. Maiden Name Annie Purnell
15. Birthplace Md

16 (a) Informant Irvin Ferguson
(b) Address 610 N. Bond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto. County, Md

18 (a) Funeral director Joseph B. Lee
(b) Address 830 N. Central Ave

AUG 27 1947
(Date received by registrar) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22, 1947, at 9a.30 M

21. I certify that I took charge of the remains described above, held an Inspect + Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 8/22/47

Cause or age is especially important. Physicians: please write the causes of death clearly and legibly.

G54645 BALTIMORE CITY HEALTH DEPARTMENT G54645
Registered No.

CERTIFICATE OF DEATH 1314

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1306 N. Central Ave
(c) Hospital or institution:
9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1306 N. Central Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** ANNIE Ruth LANCASTER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife George
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2 1892

8. AGE: Years 55 | Months | Days 23 | If less than one day hr. min.

9. Birthplace THIS. ALABAMA
(Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business

FATHER
12. Name FRANK MORSE
13. Birthplace ALA.

MOTHER
14. Maiden Name SUSIE OLIVER
15. Birthplace ALA.

16 (a) Informant George P. LANCASTER
(b) Address 1306 N. CENTRAL AVE

17 (a) BURIAL (b) Date thereof 8/29/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ARLINGTON MEM
Location

18 (a) Funeral director Joseph L. Parker
(b) Address 1364 N. Central Ave

19 (a) 1947 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG. 25 1947 at 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-4 1947 to 8-25 1947 and that I last saw her alive on 8-24 1947.

Immediate cause of death	Duration
chronic myocarditis	
(cardiac decompensation)	
Due to hypertensive cardio-renal	
Due to disease	5 CO. yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Rayner Browne
Address 1320 E. Madison St. Date signed 8/27/47

G54646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

G54646 Registered No. 6407

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 121 S. Carlton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Williams Balard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1940

8. AGE: Years 7 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Samuel M. Bilinda
13. Birthplace Scranton Pa

MOTHER
14. Maiden Name Mary L. Huntzberry
15. Birthplace Roanoke, Va.

16 (a) Informant Mrs. Chas. W. Huntzberry
(b) Address 121 S. Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 29 '47 (month) (day) (year)
(c) Cemetery or crematory Rose Hill
Location Hagerstown

18 (a) Funeral director Frederick G. Cole
(b) Address 1200 W. Fremont St.

19 (a) 1947 (Date rec'd by registrar) Huntington Williams, Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1947, at 1:45 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 20-6

(a) Date of injury 8-25-47 at 2:15 P M.
(b) Where did injury occur? Gwynn Falls Park
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place (While at work?)
(d) Means of injury Hit on head with [illegible] Drowned

23. Signature [illegible] M.D. Medical Examiner
Date signed 8-26-47

X

Please write the causes of death clearly and legibly. Physicians: please write especially important. The

G54647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

Registered No. G54647

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Charles & 31st Sts.
(c) Hospital or institution:
Homewood Apts - home
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Charles & 31st Sts.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME John Alexander Davis

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Lillie Guy Davis
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 13-1862

8. AGE: Years	Months	Days	If less than one day
84	11	12	hr. min.

9. Birthplace Statesville - N. Carolina
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Pharmacist

FATHER
12. Name JACOB A. DAVIS
13. Birthplace NORTH CAROLINA

MOTHER
14. Maiden Name ADELIA J. ALLEN
15. Birthplace NORTH CAROLINA

16 (a) Informant Miss Ethel Davis - Daughter
(b) Address Homewood Apts. - City

17 (a) Cremation (b) Date thereof 8-28-47
(Burial, cremation, or removal) (month) (day) (year)
(c) ~~Cemetery~~ crematory Greenmount
Location Balto. - Md.

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. MOWEN SUC.) 900 N. HOWARD AVENUE

19 (a) Huntington Williams M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1947, at 11.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1 1947 to August 25 1947, and that I last saw him alive on August 24 1947.

Immediate cause of death	Duration
Cardio - respiratory failure	
Due to Myocardial degeneration	
Due to arteriosclerotic cardio-vascular disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howland Edward Day M. D.
Address 4 - E - 33rd St Date signed 8/26/47

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

245 150

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G54648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47-L G54648

Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2da
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 614 N. Broadway.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Horace B. Miller. (Horace Beaumont Miller)

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Ruby E. Miller
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) 2-14-05

8. AGE: Years 42 | Months 6 | Days 13 | If less than one day: hr. min.

9. Birthplace: Penn.
(Town, county, and state)

10. Usual Occupation: Hotel Manager
11. Industry or business

FATHER
12. Name: Harry B. Miller
13. Birthplace: Ohio

MOTHER
14. Maiden Name: Mamie Trainum
15. Birthplace: Penn.

16 (a) Informant: Records.
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 8-29-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location: Port Republic, Va

18 (a) Funeral director: HENRY SANDER & SONS, INC
(b) Address: NORTH AVE. & BROADWAY

19 (a) AUG 27 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27 1947, at 6.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 25 1947, to Aug. 27 1947, and that I last saw him alive on Aug. 27 1947.

Immediate cause of death	Duration
Cachexia	
Due to Carcinoma of mouth, tongue & mandible.	1 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. S. Moran M. D.
Address JHH Date signed 8-27-47

V S 150

G54649 BALTIMORE CITY HEALTH DEPARTMENT ✓ G54649
CERTIFICATE OF DEATH 54B Registered No.

Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1767 Darley ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Chas. Ritterpusch (CHARLES LOUIS RITTERPUSCH)

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Margaret (Biemiller)
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) August 9, 1883

8. AGE: Years	Months	Days	If less than one day
64	0	16	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name Conrad Ritterpusch
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Anna ?
15. Birthplace Germany

16 (a) Informant Charles H. Ritterpusch
(b) Address 4801 York Road - 18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/29/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

AUG 27 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-25 1947, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-24 1947 to 8-25 1947, and that I last saw h~~im~~ alive on 8-25 1947.

Immediate cause of death	Duration
Respiratory Failure	
Due to Increased intracranial pressure	
Due to (Possible brain tumor)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 8-24-47
Major findings of operation: Suppos. increased intracranial press
of autopsy: Gross & micro. not yet completed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature A R Mauskopf M. D.
Address Univ. Hospital Date signed 8-26

G54650
TN. 110010

BALTIMORE CITY HEALTH DEPARTMENT ✓
CERTIFICATE OF DEATH 23d

G54650
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. WRITE WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4- & 8 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1902 Pennsylvania Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie Blake

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Col
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4th 1875

8. AGE: Years 72 | Months 1 | Days 22 | If less than one day ..... hr. ..... min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name George Washington
13. Birthplace Va.

MOTHER
14. Maiden Name Martha ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-29-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md

18 (a) Funeral director Wilson A. Jarboe
(b) Address 916 Penna. Ave

19 (a) Thurlington Williams M.D. (Date rec'd by registrar) Registrar

AUG 27 1947

MEDICAL CERTIFICATION A.M

20. DATE OF DEATH Aug. 26/1947 19 , at 2.00 M

21. I certify that death occurred on the date above stated; that I attended deceased from April/18/19 1947 to Aug. 26/ 19 47 and that I last saw her alive on Aug. 26 19 47

Immediate cause of death Cerebral Vascular Accident. — Duration

Due to Hypertensive Cardio-vascular disease

Due to

Other Conditions Arteriosclerosis generalized
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Kuehn M.D.
Address Balt. City Hosp. Date signed 8/ Aug 27

G54651

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G54651
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1706 Mosher St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Ella Holliday

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct, 31, 1896

8. AGE: Years 48 50 | Months 9 | Days 28 | If less than one day ....hr. ....min.

9. Birthplace Middlesex Co., Virginia
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Fred Holliday
13. Birthplace Virginia

MOTHER
14. Maiden Name Unknown
15. Birthplace " "

16 (a) Informant Louise Neal
(b) Address 1216 E. Monuement Stret

17 (a) Burial (b) Date thereof 8-29-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore

18 (a) Funeral director Hilleary & Jos. Kland
(b) Address 716 N. [illegible] Ave Huntington Station, Md.

19 (a) 8-27 1947
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27th 1947, at 3.7 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Carcinoma of breast
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William L Kelsh M.D.
Medical Examiner
Date signed Aug 27, 1947

VS 151

Please write the causes of death clearly and legibly. Physicians: please write as especially important.

G54652

BALTIMORE CITY HEALTH DEPARTMENT ✓ X G54652

CERTIFICATE OF DEATH 170 C

Registered No.

Please write the causes of death clearly and legibly. The information should be carefully supplied. The age as especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7½ mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County St. Mary's
(c) City or town Mechanicsville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ~~William~~ William W. ~~Holt~~ Holt

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Alice

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years	Months	Days	If less than one day
43			hr. min.

9. Birthplace St. Mary's Co. Md. (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER 12. Name James Holt
13. Birthplace St Mary's Co
MOTHER 14. Maiden Name Susan Young
15. Birthplace St Mary's Co.

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/29/47 (month) (day) (year)
(c) Cemetery or crematory ST JOSEPH'S
Location MORGANZA MD.

18 (a) Funeral director ELMER M. Wade
(b) Address Hughesville Md.

19 (a) 1947 (Date filed by registrar) (b) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 26, 1947, at 8 05 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, ~~or~~ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of neck.
Crushing of spinal cord.
Due to Cystitis.
Pyelitis.
Other Conditions Bed-sores.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 66-00
(a) Date of injury 7-6-47 at 1 P. M.
(b) Where did injury occur? Mechanicsville Md
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Fell from tractor

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 8-27-47

G54653

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 47 d

G54653
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. — PRINT, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 46 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Talbot
(c) City or town Cardova
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Archer Munday

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~.
M	Negro	Married

6 (b) Name of husband or wife Norah Munday
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15-1884

8. AGE: Years	Months	Days	If less than one day
63	7	12	hr. min.

9. Birthplace Talbot County, Md.
(Town, county and state)
10. Usual Occupation Laborer
11. Industry or business —

FATHER
12. Name Henry Munday
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Wilkins
15. Birthplace Md.

16 (a) Informant Norah Munday
(b) Address Queen Annes Co Md

17 (a) Burial (b) Date thereof 8/31/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Newtowne
Location Near Cardova Md.

18 (a) Funeral director R. B. Rawlings
(b) Address Greensboro Md.

19 (a) (b) Washington Hill
(Date filed by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27 1947 at 12 20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from August 1 19 47 to Aug 27 19 47 and that I last saw him alive on Aug. 26 19 47

Immediate cause of death Hepatoma
Collapse Malnutrition

Duration

Due to Fractured esophagus
Jan 1947

Due to Carcinoma, liver

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation July 25
Major findings of operation: Gastrostomy performed
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ed Young Jr.
Address Londale & Greene Date signed 8/30/47 M.D.

G54654

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No. G54654

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 117 E Cross Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 54

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 117 E. Cross St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Elizabeth Petrola

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. widowed.

6 (b) Name of husband or wife. Vincent Petrola

6 (c) If alive, give age \ years

7. Birth date of deceased (mo., day, yr.) Oct. 25, 1868

8. AGE: Years 78 | Months 10 | Days 2 | If less than one day hr. min.

9. Birthplace Washington D.C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name George Downing

13. Birthplace Washington, D.C.

MOTHER 14. Maiden Name Anna Williams

15. Birthplace Washington D.C.

16 (a) Informant Mrs Idcie Knight

(b) Address Washington, DC.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 30 1947 (month) (day) (year)

(c) Cemetery or crematory Congressional

Location Washington, DC.

18 (a) Funeral director Warner E. Shaughnessy

(b) Address Silver Spring Md.

19 (a) AUG 28 1947 (Registrar) (b) Huntington Williams Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/27 1947, at 10:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/14 1947, to 8/27 1947, and that I last saw her alive on 8/27 1947.

Immediate cause of death: Arteriosclerotic heart disease — Duration 15 y

Due to Generalized arterio-sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Julian Lee M. D.

Address 2303 Sulgrave Ave Date signed 8/27/47

G51655 Off# E-17568

BALTIMORE CITY HEALTH DEPARTMENT 186a

CERTIFICATE OF DEATH G54655

Registered No. [redacted]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 hrs
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 821 N. Calvert Street
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Jean Angel

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	child

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 26-47

8. AGE: Years	Months	Days	If less than one day
2	7	1	..... hr. ..... min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER
12. Name Paul W Angel
13. Birthplace Va.

MOTHER
14. Maiden Name Delia Webster Bruce Webster
15. Birthplace N. C.

16 (a) Informant Paul W Angel
(b) Address 821 N Calvert St

17 (a) Burial (b) Date thereof 8/29/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location Balto

18 (a) Funeral director Wm Cook Jr
(b) Address 217 St Paul St

19 (a) Hampton Williams, AUG 28 1947
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-27- 1947, at 12:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Intracranial Hemorrhage

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 12-5
(a) Date of injury 8-26- at 4 P.M.
(b) Where did injury occur? 821 N. Calvert St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury? Fell from 2nd floor rear porch.

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 8-27-47

VS 151

Please write the causes of death clearly and legibly. The ... specially important. Physicians:

G54656 64 477353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

Registered No. G54656

TN. 113285

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. USE INDELIBLE PENCIL, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 916 S. Hanover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME H Joyce Hollansworth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 29th 1947

8. AGE: Years	Months	Days	If less than one day
	4	27	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Russell Lee Hollansworth
13. Birthplace W. Va.

MOTHER
14. Maiden Name Truman Osborne
15. Birthplace W. Va.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/47 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Towson Balto Co.

18 (a) Funeral director Wm Cook Inc
(b) Address 317 St Paul St

19 (a) Huntington Williams, Mgr. (Date rec'd by registrar) AUG 28 1947 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26th 1947, at 6.20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 24th 1947, to Aug. 26/ 1947, and that I last saw h.e.r. alive on Aug 26th 1947.

Immediate cause of death	Duration
Cardiac Failure	2 days
Due to Diarrhea	5 days
Due to	
Other Conditions Pulmonary Edema	2 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Dilated heart, edema, fatty liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Julian P. Griffin M. D.
Address Balt City Hospitals Date signed 27 Aug. 1947

G54657

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93d

Registered No. G54657 (over)

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Rosemont (If outside city or town limits, write RURAL and give town)
(d) Street No. 3003 Maryland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louise McDaniel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 17 1858

8. AGE: Years	Months	Days	If less than one day
88	11	10	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Retired Carpenter

11. Industry or business

FATHER
12. Name John F. McDaniel
13. Birthplace Md

MOTHER
14. Maiden Name Addie C Henderson
15. Birthplace Md

16 (a) Informant Robert F Cook
(b) Address 3020 Louisiana Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/47 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Balto.

18 (a) Funeral director Wm Cook Inc
(b) Address 217 E Saratoga St

19 (a) Huntington Williams M.D. (Date rec'd by registrar) AUG 28 1947 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1947 at 9:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7:25 PM Aug 26 1947 to 9:25 PM Aug 26 1947 and that I last saw h.m alive on August 26 1947.

Immediate cause of death	Duration
Ventricular Fibrillation	
Due to Pulmonary Embolism &	
Due to Arteriosclerosis Cardiac Vascular	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. A. Hightower M. D.
Address Univ. Hosp. Date signed 8-26-47

X

G54658

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G54658

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto Hosp. 15-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2030 N. Fulton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie (Millstein) Milstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER
12. Name Isadore Schubeltzer
13. Birthplace Poland

MOTHER
14. Maiden Name Henda Leah
15. Birthplace Poland

16 (a) Informant Samuel Milstein
(b) Address 2030 N. Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Young Men's Cemetery
Location Windsor Mill Rd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-26 W. North ave

19 AUG 28 1947 (Date received by local registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27th 1947, at 2 45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured Skull
Intracranial Hemorrhage
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 15/4
(a) Date of injury 8/27/47 at 7 A. M.
(b) Where did injury occur? 2030 N. Fulton ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Fell from 2nd fl. window to pavement

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 8/27/47

Please write the causes of death clearly and legibly. Physicians: please write

G54659

BALTIMORE CITY HEALTH DEPARTMENT 932 V G54659

CERTIFICATE OF DEATH 6855 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2842 Parkwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-4
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2842 Parkwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman Stiefel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 72 Months Days If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER 12. Name Isaac Stiefel
13. Birthplace Germany

MOTHER 14. Maiden Name Yetta Meyers
15. Birthplace Germany

16 (a) Informant Irvin Stiefel
(b) Address 2842 Parkwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 28, 1947 (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew Cemetery
Location Belair Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) AUG 28 1947 (b) Washington Nitzberg, M.D.

V S 150

MEDICAL CERTIFICATION 7.10

20. DATE OF DEATH August 26 1947, at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947, to Aug 26 1947, and that I last saw him alive on 8/26 1947.

Immediate cause of death	Duration
Acute Cardiac Failure	
Due to Chronic Myocarditis	
Due to Coronary Sclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Hamaker M. D.
Address 733 Augusta St Date signed 8/28/47

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C54660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V 192

Registered No. C54660

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Use typewriter or information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto City Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Emory
(If outside city or town limits, write RURAL and give town)
(d) Street No. 510 Franklin st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nancy Zeberlein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1937

8. AGE: Years	Months	Days	If less than one day
10	2		hr. min.

9. Birthplace Balto Md
(Town, county and state)

10. Usual Occupation School Girl

11. Industry or business

FATHER
12. Name Geo M. Zeberlein
13. Birthplace Balto Md

MOTHER
14. Maiden Name Eliz M. Reuter
15. Birthplace Balto Md

16 (a) Informant Mrs. Geo Zeberlein
(b) Address 510 Franklin Ave

17 (a) Burial (b) Date thereof Aug-30-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director John B. Connelly
(b) Address 414 Eastern Ave.

AUG 28 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/26/47 1947, at 7:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardiac Failure

Due to Lightning

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 53-00
(a) Date of injury 8-26-47 at 6:30 P.M.
(b) Where did injury occur? 510 Franklin Blk.
(c) Did injury occur at home, on farm, industrial place, in public place? In Front of Home While at work? no
(d) Means of injury Struck by lightning

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 8-27-47

VS 181

G54661

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93d

Registered No. G54661

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3505 Lough St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John C. Schmeiser

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Separated

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 23-1889

8. AGE: Years	Months	Days	If less than one day
58	4	3	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Butcher
11. Industry or business

FATHER
12. Name Christian Schmeiser
13. Birthplace Balto Md

MOTHER
14. Maiden Name Marg. Volz
15. Birthplace Balto Md

16 (a) Informant Mrs. Rita Litzinger
(b) Address 8307 Shila Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 29-47 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto Md

18 (a) Funeral director John F. Donnelly
(b) Address 408 Eastern Ave

19 (a) AUG 28 1947 (b) Huntington Williams, M.D. Registrar
Registered by

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1947, at 9:35 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions Chronic Valvulitis; Chronic myocarditis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D. Medical Examiner
Date signed 8-26-47

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied. The

G54662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1932

Registered No. G54662

The entry of every item of information should be carefully supplied. Write plainly, with unfading ink. Every item must be answered or the word "unknown" inserted where the information cannot be obtained. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1527 E Jefferson st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 5
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1527 E. Jefferson st
(Insert definitive location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Commons Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Alfreda Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug-12-1879

8. AGE: Years 68 | Months | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Peter Bonds
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Jane ?
15. Birthplace Baltimore, Md.

16 (a) Informant Mamie Corbin
(b) Address 602 N. Eden st

17 (a) F (Burial, cremation, or removal) (b) Date thereof Aug. 26, 1947 (month) (day) (year)

(c) Cemetery or crematory Arlington Mem. Pk.
Location Baltimore Co., Md.

18 (a) Funeral director J. Preston Funeral Home
(b) Address 519 Hamilton Ave, Huntingdon Station, Md.

19 AUG 28 1947 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug- 24 1947, at 10:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/15 1947 to 8/24 1947 and that I last saw h[illegible] alive on 8/24/47

Immediate cause of death: Myocarditis — Duration 90 dys
Due to: Sclerosis — Duration indef.
Due to:
Other Conditions: Cholecystitis — Duration 60 dys
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jas. R. Blake M. D.
Address 1327 N. Central Ave Date signed 8/28/47

G51663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No. G54663

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1202 Warner St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 7yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1202 Warner St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Anna May Seibel

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
no	none	female	white	widowed

6 (b) Name of husband or wife Charles A. Seibel 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1874

8. AGE: Years	Months	Days	If less than one day: hr.	min.
73	3	15		

9. Birthplace Plainfield N. J. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business —

FATHER
12. Name ? Priestley
13. Birthplace U. S. A.

MOTHER
14. Maiden Name Eleanor ?
15. Birthplace U.S.A.

16 (a) Informant Rose Eleanor Keegan
(b) Address 1202 Warner St.

17 (a) removal (Burial, cremation, or removal) (b) Date thereof 8/29/47 (month) (day) (year)
(c) Cemetery or crematory Greenwood
Location Trenton, N. J.

18 (a) Funeral director M. W. E. Dispatch Service
(b) Address 1420 E. Lombard St.

AUG 28 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27 1947, at 3 45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-22-1947 to 8-27-1947, and that I last saw h[illegible] alive on 8-27-1947.

Immediate cause of death Acute Cardiac Dilation — Duration: From min. Dy

Due to Myocarditis Chronic — From years

Due to Arteriosclerosis Pulmonary (Hypertension) — From years

Other Conditions Old age. — From years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James Graham Manton M.D.
Address 516 Cathedral Date signed 8-28-47

G54664

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G54664 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3652 Malden Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3652 Malden Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John W. Bassler.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower.

6 (b) Name of husband or wife Lena Bassler.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3, 1857

8. AGE: Years	Months	Days	If less than one day
90	4	23	hr. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Jacob Bassler.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Caroline ?.
15. Birthplace Maryland.

16 (a) Informant John E. Bassler.
(b) Address 1111 W. 42nd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 29/47 (month) (day) (year)
(c) Cemetery or crematory Sater's
Location Balto. Co. Md.

18 (a) Funeral director Chenoweth & Donovan.
(b) Address 3615 17 Chestnut Ave.

19 (a) Aug 28 1947 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION P.

20. DATE OF DEATH August 26, 1947, at 1.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1944 to Aug 26 1947. and that I last saw him alive on Aug 25 47.

Immediate cause of death: Congestive Heart Failure — Duration
Due to: Coronary Thrombosis
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edw. L. Hassman
Address 403 7 Falls Rd Date signed 8/27/47 M. D.

X

G54665

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G54665

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRESS WHITE FIRMLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2522 E Federal St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2522 E Federal St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Russell Thorpe

3 (b) If veteran, name war

3 (c) Social Security Account No. 119-10-7332

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Minnie O Thorpe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug 4 1868

8. AGE: Years	Months	Days	If less than one day
79		23	hr. min.

9. Birthplace Cincinatti Ohio
(Town, county, and state)
10. Usual Occupation Retired Stationery Engineer
11. Industry or business Voneiff Drayage Co

FATHER
12. Name William Abner
13. Birthplace Cincinatti Ohio

MOTHER
14. Maiden Name Elizabeth Bolmer
15. Birthplace Cincinatti Ohio

16 (a) Informant Minnie O Thorpe
(b) Address 2522 E Federal St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 30 1947 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director John C Miller Inc
(b) Address 2433 E Oliver St

19 AUG 28 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27th 1947, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1947, to Aug 27th 1947 and that I last saw h. alive on Aug 27 1947.

Immediate cause of death	Duration
Cardio-Vascular Renal Disease	5 yrs
Due to Hypertension	2
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George D Cross M.D.
Address 28 W 20th St Date signed 8-27-47

G54666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G54666 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1945 Penna Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1945 Penna Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Buteway

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife

6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) May 10, 1898

8. AGE: Years	Months	Days	If less than one day
49	3	14	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Beulah Buteway
(b) Address 1945 Penna Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Md

18 (a) Funeral director Geo. B. Kelso
(b) Address 1303 Pennsylvania Ave

19 (Date rec'd by registrar) AUG 28 1947 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 24 1947; at 1045 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 2 1947, to Aug 24 1947, and that I last saw him alive on Aug 22 1947

Immediate cause of death Cardio Vascular Renal Disease — Duration 6 mo 1/2

Due to Broken Compression — Duration 8/2/47

Due to — Duration

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William Fray
Address 1928 Penna Ave Date signed 8/27/47

G54667

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 b

Registered No. G54667

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4343 Reisterstown Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 13
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4343 Reisterstown Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES H. PRENTISS

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	widower

6 (b) Name of husband or wife Cora G. Prentiss
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 13, 1877

8. AGE: Years	Months	Days	If less than one day
70	3	13	hr. min.

9. Birthplace York, Pa.
(Town, county, and state)
10. Usual Occupation Sales Representative
11. Industry or business Eppens-Smith & Co.

FATHER
12. Name Samuel Prentiss
13. Birthplace

MOTHER
14. Maiden Name Emma Geipe
15. Birthplace York, Pa.

16 (a) Informant Miss Estella Prentiss
(b) Address 4343 Reisterstown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/29/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) AUG 28 1947 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION p

20. DATE OF DEATH August 26, 1947, at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 19 1947, to Aug 26 1947, and that I last saw h[illegible] alive on Aug 26 1947.

Immediate cause of death	Duration
Cardiac Asthenia	3 days
and Hypostatic Pneumonia	5 days
following Cerebral Thrombosis	2 weeks
Due to Thrombosis of Splenic and Intestine	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation No Operation
Major findings of operation:
of autopsy No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Frederick L. Zepp M. D.
Address 3402 Hamilton Ave Balto 16 Md Date signed 8/27/47

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54668

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
1942

G54668 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 33rd st & Calvert
(b) Street address [redacted]
(c) Hospital or institution:
Union Memorial Hospital q-6
(d) Length of stay in hospital or inst. ~~(yrs., mos.,~~ or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 East 31st City If rural give location
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Q. Taylor Busick

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 218-07-6492

4. Sex Male

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: MARRIED.

6 (b) Name of ~~husband~~ or wife: Nettie O. Busick

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-23-1861

8. AGE: Years 86 | Months 7 | Days 4 | If less than one day hr. min.

9. Birthplace Maryland (Balto.)
(town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Armstrong Stove Co.

FATHER
12. Name Joshua Wells Busick
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Kate Boyer
15. Birthplace Maryland

16 (a) Informant Mr. Robert Wells Busick
(b) Address 600 Stoneleigh Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/29/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) AUG 28 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-27 1947, at 7:56 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-25 1947 to 8-27 1947 and that I last saw h a m. alive on 8-27 1947

Immediate cause of death Acute Congestive Heart failure — Duration

Due to Generalized Arterio-sclerotic Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Coronary sclerosis + hypertrophy + dilatation of heart

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. C. Williams M. D.
Address Union Memorial Date signed

VS 150

Hosp X 8-27-47

FORMS WHITE COUNTY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54669

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G54669

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. Stansbury Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex 7

5. Color or race Col.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1923

8. AGE: Years 24 | Months | Days | If less than one day hr. min.

9. Birthplace Suffolk Va (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name ? Sharps

13. Birthplace Virginia

MOTHER 14. Maiden Name Mary Sharps

15. Birthplace Virginia

16 (a) Informant Norman Mitchell

(b) Address Rout 3 Dundalk Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 29 47 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem.

Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson

(b) Address 1015 Edmondson Ave

19 (a) Aug 28 1947 (Date received by Registrar) (b) Huntington Indiana, Md

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-24- 1947, at 12.55 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Extensive Burns (second- and third- degree)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death fill in the following:
(a) Date of injury 8-24-47 at 53.00 ? A. M.
(b) Where did injury occur? Stansbury Rd-Dundalk
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Kerosene into which Kitchen set afire.

23. Signature George L. Merrill M.D. Medical Examiner.

Date signed 8-25-47

G54670

BALTIMORE CITY HEALTH DEPARTMENT 134 G54670
CERTIFICATE OF DEATH Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 608 Gold St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15d
(e) Length of stay in Baltimore (yrs., mos., or days) 67

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 608 Gold St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry E. Briscoe
3 (b) If veteran, name war
3 (c) Social Security Account No. 214-01-8063

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife Harriett Briscoe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 5-1879

8. AGE: Years 67 | Months 9 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Porter
11. Industry or business Dept Store

FATHER
12. Name Abraham Briscoe
13. Birthplace Unknown

MOTHER
14. Maiden Name Caroline Jones
15. Birthplace Calvert Co Md

16 (a) Informant Mrs Harriett Briscoe
(b) Address 608 Gold St

17 (a) ✓ (Burial, cremation, or removal) (b) Date thereof 8-29-47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem Pk
Location Baltimore Co

18 (a) Funeral director Mrs Geo H Holland
(b) Address 1631 Druid Hill ave

19 AUG 28 1947 (Date received by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 1947, at 9 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1947 to Aug 25 1947 and that I last saw h[illegible] alive on Aug 25 1947.

Immediate cause of death Central Apoplexy — Duration —
Due to — —
Due to — —
Other Conditions Probable Pulmonary Tuberculosis, Bronchitis — —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. Garland Shinall Jr. M. D.
Address 423 New Pittsburg Ave Date signed 8-25-47

VS 150

G54671

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160 C

Registered No. G54671

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6113 Mayflower Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6113 Mayflower Drive (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Charles Conrad Archer

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, ~~married, widowed, or divorced.~~

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 27, 1947

8. AGE: Years | Months | Days | If less than one day: hr. 25 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Harold E. Archer
13. Birthplace Frederick, Md.

MOTHER
14. Maiden Name Rosalie E. Sneeringer
15. Birthplace Frederick, Md.

16 (a) Informant Harold E. Archer
(b) Address 6113 Mayflower Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/47 (month) (day) (year)
(c) Cemetery or crematory Poplar Grove
Location Warren, Md.

18 (a) Funeral director Earl L. Hess
(b) Address 714 Light St.

19 (a) AUG 28 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27 1947, at 1:25 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 27 1947, to 1947, and that I last saw him alive on Aug. 27 1947.

Immediate cause of death: Aspiration of Amniotic Fluid. — Duration: 25 min.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. T. Cole M. D.
Address 6014 York Road Date signed 8-27-1947.

Every item of information should be carefully supplied. The write PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly.

G54672

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 552

Registered No. G54672

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1038 N. Augusta St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-1-95

8. AGE: Years	Months	Days	If less than one day
52	5	24	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Jacob Johnson
13. Birthplace N. C.

MOTHER 14. Maiden Name Johanna Gross
15. Birthplace N. C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-28-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) 1947 AUG 28 (Date rec'd by registrar) Katherine Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20.

20. DATE OF DEATH Aug 25 1947, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 8 1947 to Aug 25 1947, and that I last saw her alive on Aug 25 1947.

Immediate cause of death	Duration
Carcinoma	5 mo
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D.
Address Johns Hopkins Hosp Date signed Aug 29 1947

G54673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1843

G54673

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) ~~Hospital~~ or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 603 W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Ernestine Mosley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 26, 1930

8. AGE: Years 17 | Months 6 | Days 28 | If less than one day ____hr. ____min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name Burt Mosley
13. Birthplace Greensboro N.C.

MOTHER
14. Maiden Name Lillian Holcomb
15. Birthplace Mottaway Co. Va.

16 (a) Informant Burt Mosley
(b) Address 603 W. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8- 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Mrs Katie B Williams
(b) Address 322 N Schroeder St

AUG 28 1947 (Date rec'd by registrar)

(b) Funeral Director for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 24 1947, at 3'15 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Asphyxiation due to drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-24-47 at 4:30 A.M.
(b) Where did injury occur? City Harbor Pier 4 - Pratt St
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
Means of injury Found drowned

23. Signature Howard J. Meredith M.D. Medical Examiner.
Date signed 8-25-47

VS 181

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47d

G54674 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write plainly, WITH UNFADING INK. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 937 W. Lexington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 937 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Scott.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Martina Scott

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1906

8. AGE: Years 41 | Months 5 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Chemical Worker

11. Industry or business

FATHER 12. Name William Scott.

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Anna Gibson

15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Martina Scott

(b) Address 937 W. Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-30-1947 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Mrs Katie B. Williams

(b) Address 322 N. Schroeder St

19 (a) 1947 (Date received by registrar) (b)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 Aug. 1947, at 6.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1946 to 26 Aug. 1947 and that I last saw him alive on 26 Aug. 1947.

Immediate cause of death Primary Carcinoma

Due to of Lt. Lung.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: years

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles Townsend M.D. M. D.

Address 910 W. Lombard St. Date signed 27 Aug. 47.

G54675

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V131a

Registered No. G54675

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WHITE PAPER, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 629 McKeown Ave.
(c) Hospital or institution: 9-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 77

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town write RURAL and give town)
(d) Street No. 629 McKeown Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia C. Bunn
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex F
5. Color or race W.
6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife Joseph F. Bunn
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 30, 1870
8. AGE: Years 76 Months 77 Days 8 Hours 26 If less than one day hr. min.
9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Housewife
11. Industry or business
FATHER 12. Name Christian Kremer
13. Birthplace Germany
MOTHER 14. Maiden Name Anna M. Enders
15. Birthplace Germany
16 (a) Informant Joseph P. Bunn
(b) Address 326 N Greenmount Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-29-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location
18 (a) Funeral director John A. Moran
(b) Address 300 E. Balt St.
19 (a) AUG 28 1947 (b) Interred Williamsport Md

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26th. 1947, at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/16/1947 to 8/26/1947; and that I last saw her alive on 8/25 1947.

Immediate cause of death: Uremia — Duration: 3 days
Due to: Chronic Interstitial Nephritis — Duration: unknown
Due to: ------- -- —
Other Conditions: Endocarditis — Duration: unknown

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jos. W. Morgan M.D.
Address 401 E. 25th. St. Date signed 8/29/47.

V S 150

G54676

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 d

G54676 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 446 N. Patterson Park Ave.
(c) Hospital or institution:
to
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
3
(d) Street No. 446 N. Patterson Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine George

3 (b) If veteran, name war ---
3 (c) Social Security Account No. ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Herman Goerge
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19, 1861

8. AGE: Years	Months	Days	If less than one day
86	1	7	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John Schick
13. Birthplace Germany

MOTHER
14. Maiden Name Leona Dunnenfelser
15. Birthplace Germany

16 (a) Informant Mrs. Elizabeth Schmuff
(b) Address 446 N. Pat. Park Ave.

17 (a) Burail (Burial, cremation, or removal) (b) Date thereof Aug. 30/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto. Md.

18 (a) Funeral director Philip Lewis & Sons
(b) Address 2024 Orleans St.

19 AUG 28 1947 (c) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 26/47 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-19- 1946 to 8-26- 1947, and that I last saw h[illegible] alive on 8-26- 1947

Immediate cause of death	Duration
Coronary Thrombosis	1 Hour
Due to Arteriosclerotic Heart Disease.	10 Years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benj. B. Mason M. D.
Address 448 N. Longwood and Date signed 8-27-47

X

V S 150

G54677

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G54677
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1611 Hanover
(c) Hospital or institution: 23-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1611 Hanover St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Latcham

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife William H. Latcham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 6, 1873

8. AGE: Years	Months	Days	If less than one day
74		21	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Hartlove
13. Birthplace Md

MOTHER
14. Maiden Name Mary Lawson
15. Birthplace Md

16. (a) Informant Audrey Copeland
(b) Address 1527 N Charles St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 29 1947 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location Balto

18. (a) Funeral director A. Reginald Evans
(b) Address 1400 N Charles St

19. (a) (Date rec'd from registrar) (b) Washington Williams Registrar

AUG 28 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1947, at 6:30 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 8/23 1947 to 8/27 1947 and that I last saw h alive on 19

Immediate cause of death	Duration
Coronary Thrombosis	5 days
Due to —	
Due to —	
Other Conditions Hypertensive cardio 4 yrs	
Contributory disease	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: —

PHYSICIAN - Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Lockard
Address 916 Hanover St Date signed 8/25/47

X

G54678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G54678

The entry of information should be carefully supplied. PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green & Redwood Sts.
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1817 Frederick Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3 (a) FULL NAME JOHN HENRY RITTER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Margaret M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 15, 1868

8. AGE: Years	Months	Days	If less than one day
78	8	11	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Francis X. Ritter

FATHER 13. Birthplace Md.

MOTHER 14. Maiden Name Sarah Imhoff

MOTHER 15. Birthplace Md.

16 (a) Informant Mrs. Lillian Ritter

(b) Address 1817 Frederick Ave

17 (a) Burial (b) Date thereof 8-29-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Catholic

Location Baltimore

18 (a) Funeral director George A Farley

(b) Address Fulton Ave & Laurens St.

19 AUG 28 1947 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-26 1947, at 2:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 24 1947 to Aug 26 1947, and that I last saw h alive on Aug 26 1947

Immediate cause of death	Respiratory failure	
Due to	Cerebral Vascular accident	
Due to	Hypertension & arteriosclerosis	
Other Conditions	Diabetes	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. C. Durall Jr. M. D.
Address Univ. Hosp. Date signed Aug 26

83

G54679

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 L

Registered No. G54679

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 da
(e) Length of stay in Baltimore (yrs., mos., or days) ~~28~~

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1311 Bayard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Jerome Fisher

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Negro	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 28. 1886

8. AGE: Years	Months	Days	If less than one day
60	7	28	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Charles Fisher
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Fisher
15. Birthplace

16 (a) Informant Virginia Brooks
(b) Address 131 D Bayard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 31. 1947 (month) (day) (year)
(c) Cemetery or crematory Mount Lebanon
Location Baltimore County Maryland

18 (a) Funeral director Joseph A. Lively
(b) Address 66 West Baltimore Street

19 AUG 28 1947 (Signature of local registrar) Huntington Williams Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1947 at 11.0 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1947 to Aug 26 1947 and that I last saw h[illegible] alive on Aug 20 1947

Immediate cause of death	Duration
Carcinoma of Stomach	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C B Heaver M. D.
Address Univ. Hosp. Date signed 8-26-47

TG54680

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G54680

PRINTER'S NOTE: USE BLACK INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 478 Cummings Ct.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 478 Cummings Ct. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella H. Copper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	C	Widowed

6 (b) Name of husband or wife Jordan Copper
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 28, 1891

8. AGE: Years	Months	Days	If less than one day
56	5	29	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Andrew Jones
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Fannie Jackson
(b) Address 1301 East St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-30-47 (month) (day) (year)
(c) Cemetery or crematory Arlington Cemetery
Location Maryland

18 (a) Funeral director Adolphus Gaithead
(b) Address 918 Druid Hill Ave.

19 (a) (Signature of local registrar) (b) Huntington Williams, M.D.

AUG 28 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27 1947, at 12 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1- 1947 to 8-27 1947 and that I last saw h[illegible] alive on 8-27- 1947

Immediate cause of death	Duration
Bronchio Pneumonia	4 Days
Due to Exposure & Colds	
Due to Arteriosclerosis & Hemiplegia	6 mos

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. R. Blake M.D.
Address 1327 N. Carrollton Ave. Date signed 8/27/47

G54681

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1942

G54681 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Eight St.
(c) Hospital or institution: So. Balti. gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County [redacted]
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2695½ Wilkens Ave
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henrietta Heiland

3 (b) If veteran, name war: None.
3 (c) Social Security Account No.: None.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Carl Heiland
6 (c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): July-19-1873

8. AGE: Years: 74 | Months: 1 | Days: 8 | If less than one day: hr. min.

9. Birthplace: Baltimore-Md. (Town, county, and state)
10. Usual Occupation: Home Wife.
11. Industry or business: At home.

FATHER
12. Name: Adam Gebring
13. Birthplace: Austria.

MOTHER
14. Maiden Name: Caroline Hinkel.
15. Birthplace: Md.

16 (a) Informant: Carl Heiland.
(b) Address: 2695½ Wilkens Ave.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof: Aug. 30-42 (Month) (day) (year)
(c) Cemetery or crematory: Meadow Ridge Cem.
Location: Dorsey-Md.

18 (a) Funeral director: Charles J. Schuck
(b) Address: 3512 Frederick Ave.

AUG 29 1942 (Date rec'd by Registrar)
(b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/27 1942, at 7:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/26 1942, to 8/27 1942, and that I last saw her alive on 8/27 1942.

Immediate cause of death: Cardiac failure — Duration:

Due to: Arteriosclerotic heart disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: H. W. Cooper
Address: S. B. G. H. Date signed: 8/27/42

G54682

BALTIMORE CITY HEALTH DEPARTMENT

CWK-113375

CERTIFICATE OF DEATH 136

G54682 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1307 E. Baltimore Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Pack

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Grace Mae Pack
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 18-1915

8. AGE: Years 32 | Months 9 7 | Days 10 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Archie Earl (D)
13. Birthplace Virginia

MOTHER
14. Maiden Name Virginia Scott
15. Birthplace Virginia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Transit (Burial, cremation, or removal) (b) Date thereof Aug 29-47 (month) (day) (year)
(c) Cemetery or crematory Beatisburg
Location Giles Co. Virginia

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St

19 (a) (b) (Date received by registrar) Huntington, W. Va.

AUG 29 1947

V5-150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1947, at 12 Noon

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 27 1947 to Aug. 28 1947 and that I last saw h im alive on Aug. 28 1947.

	Duration
Immediate cause of death: Tuberculous Meningitis	2 hrs
Due to: Pulmonary Tuberculosis	4 yrs.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Laurence Lee Jr. M. D.
Address Balt City Hosp. Date signed 8-28-47

G51683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 B

G51683 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 805 N. Madeira St (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No) If yes, name country America

3 (a) FULL NAME George John Kirchner

3 (b) If veteran, name war	3 (c) Social Security Account No.
Yes War?	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Queen Elizabeth Kirchner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23 1890

8. AGE: Years	Months	Days	If less than one day
57	2	5	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Kirchner
13. Birthplace Balto

MOTHER
14. Maiden Name Anna Stock
15. Birthplace Balto.

16 (a) Informant Patient + wife Henry B. Wilson
(b) Address Church Home Hosp.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 1-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto.

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St.

19 (a) AUG 29 1947 (Local registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June Aug 28 1947 at 3:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 25 1947 to Aug 28 1947 and that I last saw him alive on Aug 28 1947.

Immediate cause of death Kidney Insufficiency — Duration 3 wks?
Due to Hydro-pyo nephrosis
Due to Carcinoma of Bladder
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation Aug. 26, 1947
Major findings of operation Bladder Tumor
of autopsy Carcinoma Bladder

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry B. Wilson
Address Church Home Hospital Date signed Aug 28 1947 D.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINTING WITH UNFADING INK. Every item of information should be carefully supplied.

G54684

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G54684
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. 71 John St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret J. Bangs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Wilbur

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 4 1883

8. AGE: Years	Months	Days	If less than one day
59	0	14	hr. min.

9. Birthplace Westminster, Carroll Co Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Glenn D Buckingham
13. Birthplace Carroll Co Md

MOTHER
14. Maiden Name Elizabeth Boylan
15. Birthplace Ireland

16 (a) Informant Wilbur Bangs
(b) Address 71 John St Westminster Md

17 (a) Burial (b) Date thereof Sept 1-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Johns Cem.
Location Westminster, Md.

18 (a) Funeral director H. Bankard & Son
(b) Address Westminster, Md.

19 (a) AUG 29 1947 (b) Huntington Williams, M.D.
(Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 Aug 1947, at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3 Aug 1947, to 28 Aug 1947, and that I last saw her alive on 28 Aug 1947

Immediate cause of death Uremia — Duration 3 weeks ?

Due to Arteriosclerotic Renal Disease — 2

Due to Acute Nephritis — 2

Other Conditions Diabetes Mellitus — 10 yrs 2

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard A Carey M. D.
Address Mercy Hospital Date signed 8/28/47

131a

G51685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 174a

Registered No. G51685

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 6
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3 N. Ellwood Ave.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Elmer Rancaster.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	married

6 (b) Name of husband or wife Alice.
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) 2-15-15

8. AGE: Years	Months	Days	If less than one day
32	6	13	.....hr. .....min.

9. Birthplace Pa.
(Town, county, and state)
10. Usual Occupation Assembly man
11. Industry or business

FATHER
12. Name James S Rancaster
13. Birthplace Pa.

MOTHER
14. Maiden Name Etta S Sargent.
15. Birthplace Pa

16 (a) Informant Rhonda
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (b) Date thereof 8-30 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory OAK LAWN CEM.
Location EASTERN AVE.

18 (a) Funeral director LILLY & ZEILER INC
(b) Address 403 S. WOLFE ST.

(a) AUG 29 1947 (Date received by registrar) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Aug. 25 1947, at 12.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug-22 1947, to Aug-25 1947, and that I last saw him alive on Aug-25 1947.

Immediate cause of death	Duration
Hemorrhage into R Temporal Lobe	18 hours
Due to Chronic Myeloid Leukemia	4 years
Due to.....	.....
Other Conditions.....	.....

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy: Findings stated above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Thomas E. Van Metre JR M. D.
Address Johns Hopkins Hosp Baltimore Md Date signed 8/28/47

X

PRINT NAME PLAINLY, WITH UNFADING INK. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G54686

Every item of information should be carefully supplied. Type or write the causes of death clearly and legibly. Physicians: please write exact age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 626 S Newkirk St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 626 S. Newkirk St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Maggie G. Hearl

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife: John Hearl
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 10-13-1887

8. AGE: Years	Months	Days	If less than one day
59	2 10	13	— hr. — min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name ? Green
13. Birthplace ?

MOTHER
14. Maiden Name Annie Ruley
15. Birthplace ?

16 (a) Informant Catherine Voight
(b) Address 6405 Gilmore Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-29-47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern Ave.

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. Wolfe St.

AUG 29 1947 (b) [illegible] Williams, MD
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1947, at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1947 to Aug 26 1947. and that I last saw h[illegible] alive on Aug 26 1947.

Immediate cause of death	Duration
Coronary Occlusion	
Due to A-S-C-V-R. Disease	
Due to	
Other Conditions Coronary Occlusion in Jan 1947	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible] M.D.
Address [illegible] Date signed 8/28/47

X

G54687 BC# B 87073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G54687

Please write plainly, with unfading ink. Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville 28
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5 Hilltop Road
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Baby Female Osborne

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 8-27-47 5:30 am

8. AGE: Years | Months | Days | If less than one day: 2 hr. 25 min.

9. Birthplace St. Agnes Hospital
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Eugene Fielding Osborne
13. Birthplace Peach Bottom Penna.

MOTHER
14. Maiden Name Jennye Alice Maddux
15. Birthplace Catonsville Md.

16 (a) Informant Mrs. Jennye Maddux Osborne
(b) Address 5 Hilltop Rd. Catonsville 28

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/29/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto City

18 (a) Funeral director Edw. J. MacMahon
(b) Address Catonsville Md.

AUG 29 1947 (b) Huntington Williams
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-27- 1947, at 8:55 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/24 19__, to 8/27 1947, and that I last saw h__ alive on __/__/19__.

Immediate cause of death: Prematurity, atelectasis congenital.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. M. T. Wolfe M. D.

Address Date signed

X

G51688

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G51688 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 E. Lombard st. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Grandville Edwards

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years 42 | Months | Days | If less than one day hr. min.

9. Birthplace A. A. Co Md (Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER 12. Name James Edwards
13. Birthplace A. A. Co. Md

MOTHER 14. Maiden Name Maria Brady
15. Birthplace A. A. Co Md

16 (a) Informant Ida Hopkins
(b) Address 1505 E. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31, 1937 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem
Location A. A. Co. Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1010 Braniteyave

19 AUG 29 1937 (Date rec'd by registrar) Huntington Williams M.D. (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/27 19 37, at 8:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry), find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Rouse M.D. (Medical Examiner.)
Date signed 8/27/37

VS 181

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G54689

Every item of information should be carefully supplied. Type or write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 705
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 512 N. Mc Elderry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank C. Robinson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

Sex Male | Color or race Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-8-15

8. AGE: Years 21 | Months 11 | Days 20 | If less than one day ___ hr. ___ min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Benny Robinson
13. Birthplace Va.

MOTHER 14. Maiden Name Ella Taylor
15. Birthplace Va.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 2, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md

18 (a) Funeral director Elton O. Wilson
(b) Address 101 Bilberry ave

AUG 29 1947 (Date Rec'd by Registrar) (b) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-28-1947, at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-26 1947 to 8-28 1947 and that I last saw h[illegible] alive on 8-28 1947.

	Duration
Immediate cause of death: Pulmonary hemorrhage	3 days
Due to: pulmonary tuberculosis	10 yrs.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: the emphysema cavity - at lung

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Sisson
Address Johns Hopkins Hosp. Date signed 28 Aug 47 M. D.

G54690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G54690 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4253 Shamrock Avenue
(c) Hospital or institution: 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4253 Shamrock Avenue
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George J. Scheel

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 212-01-0051

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Hilda D. Kempf
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) March 14, 1891

8. AGE: Years	Months	Days	If less than one day
56	5	12	####### hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Manager
11. Industry or business Balto: Div. A.D.T.

FATHER
12. Name Nicholas W. Scheel
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary B. Hamper
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Hilda D. Scheel
(b) Address 4253 Shamrock Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road, Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

AUG 29 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1947, at 11:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1942 to Aug. 26 1947 and that I last saw her alive on Aug. 26 1947.

Immediate cause of death	Duration
Coronary thrombosis	48 hrs
Due to Essential hypertension	7 years
Due to Hypertensive CHV disease	
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. H. Kramer
Address 1428 Kingsway Rd. Date signed 8-28-47

G51691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G51691 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write to the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1724 N. Bentalou St.
(c) Hospital or institution:
16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 1724 N. Bentalou St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME August Kleinhenn

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 705-09-0544

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Nellie C. Kleinhenn
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) November 15, 1879.
8. AGE: Years 67 Months 9 Days 17 If less than one day hr. min.
9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Chief Mail & Express Clerk
11. Industry or business B & O. Railroad.

FATHER
12. Name Louis Kleinhenn
13. Birthplace Germany

MOTHER
14. Maiden Name ? Schmidt
15. Birthplace Germany

16 (a) Informant Mr. William Radcliffe
(b) Address Elliott City, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/31/47. (month) (day) (year)
(c) Cemetery or crematory St. John's Cemetery
Location Elliott City, Maryland.

18 (a) Funeral director Easton Sons
(b) Address Elliott City, Maryland.

AUG 29 1947 (Date rec'd by local registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug-27 1947 at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1947 to Aug 27 1947 and that I last saw him alive on May 10 1947.

Immediate cause of death	Duration
Acute Cardiac Dilatation	
Due to Diabetes Mellitus.	8 yrs.
Due to Arteriosclerosis.	2 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos. G. Lloyd
Address 126 N. Charles Date signed 8/27/47
Thomas J. Maloney, M.D.

VS 150

G54692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G54692 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2002 East Lombard St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MR. John Bowers. (BLASZKOWSKI)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife MARY Bowers
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) APRIL 25, 1892

8. AGE: Years	Months	Days	If less than one day
55	4	4/2	..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Electrician Engineer
11. Industry or business

FATHER
12. Name George Bowers
13. Birthplace Poland

MOTHER
14. Maiden Name Mary MANIEWSKA
15. Birthplace Poland

16 (a) Informant Mrs Mary Bowers.
(b) Address 2002 E. Lombard St. Balt.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9/1/47 (month) (day) (year)
(c) Cemetery or crematory St. STANISLAUS
Location MT. CARMEL Road

18 (a) Funeral director M. J. Sadowski & Sons
(b) Address 1808 Eastern Avenue

19 (a) [illegible] (b) Huntington Williams, M.D.

AUG 29 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1947 at 2:22 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 26 1947 to Aug 27 1947 and that I last saw h. l. alive on Aug 27 1947.

Immediate cause of death	Duration
Arteriosclerotic heart disease	3 weeks
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John A Fischer M. D.
Address Union Memorial Hosp. Date signed 8/28/47

X

G54693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G54693

PLEASE WRITE PLAINLY. WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hosp. ward
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1d.
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3728 Old York Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 26, 1883

8. AGE: Years 64 | Months | Days 1 | (If less than one day) hr. min.

9. Birthplace Holland. (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER
12. Name John Miller
13. Birthplace Holland

MOTHER
14. Maiden Name Christian Esther Westerik
15. Birthplace Holland.

16 (a) Informant Mrs. B. A. Trapp
(b) Address 3728 Old York Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/1/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) AUG 29 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27 1947, at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 26 1947 to Aug 27 1947 and that I last saw him alive on Aug 27 1947

Immediate cause of death: Myocardial Infarction — Duration: 2 da

Due to Arteriosclerotic Heart Disease — —

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman R. Freeman M.D.
Address Union Memorial Hosp. Date signed Aug 27 '47

G54694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 107

Registered No. G54694

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address GREENSPRING & BELVEDERE AVES.
(c) Hospital or institution: LEVINDALE HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 BROOKFIELD AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME MORRIS FRIEDMAN

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-3244

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	WHITE	MARRIED

6 (b) Name of husband or wife ANNA
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 4, 1892

8. AGE: Years	Months	Days	If less than one day
55	1	25	hr. min.

9. Birthplace BALTIMORE (Town, county, and state)
10. Usual Occupation
11. Industry or business FURNITURE SALESMAN

FATHER
12. Name ABRAHAM ADLER
13. Birthplace RUSSIA

MOTHER
14. Maiden Name SOPHIA ADLER
15. Birthplace RUSSIA

16 (a) Informant Anna Friedman
(b) Address 2101 BROOKFIELD AVE
17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8/29/47 (month) (day) (year)
(c) Cemetery or crematory MICKRO-KODESH
Location BOWLEY'S LANE
18 (a) Funeral director SOL LEVINSON & BROS
(b) Address 1124-26 W. NORTH AVE
AUG 29 1947 (b) Registrar [illegible] Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-29 1947 at 12 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-6 1946 to 8-29 1947 and that I last saw h. (m.) alive on 8-29 1947.

Immediate cause of death	Duration
Bronchopneumonia	
Due to Parkinson's disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Henry Vogel M. D.
Address Levindale Home Date signed 8-29-47

D 54695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

54695 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State ~~Md.~~ Fla. (b) County.....
(c) City or town Fernandina
(If outside city or town limits, write RURAL and give town)
(d) Street No.....
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Sarah Goolsby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Thomas Goolsby

6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) 12-2-07

8. AGE: Years	Months	Days	If less than one day
39	-	26	....hr. -....min.

9. Birthplace Ga.
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business.....

FATHER
12. Name Rev J.C.D. Brooks
13. Birthplace Ga.

MOTHER
14. Maiden name Eura Woodruff
15. Birthplace Ga.

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 8/29/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory.....
Location Jacksonville Fla.

18 (a) Funeral director John A. Mitchell Sons
(b) Address 1900 Eutaw Place

AUG 29 1947 Huntington Williams, M.D.
(Date received by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-28-1947, at 9:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-3-47, to 8-28-1947, and that I last saw her alive on 8-28-1947.

Immediate cause of death

	Duration
~~Coronary occlusion~~ perforated duodenal ulcer, collapse	6 hrs
Due to post operative shock	10 hrs
Due to.....	
Other Conditions Hypertensive cardio-vascular disease (Include pregnancy within 3 months of death)	? years

Date of operation 8/28/47

Major findings of operation: normal lung, patchy emphysema, left adrenal tumor, complete atelectasis of right lung

of autopsy [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Dale D. Foster

Address Johns Hopkins Hosp. Date signed 8/29/47 M. D.

G5 GD6

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54a

G54696

Registered No. G54696

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Colon + 33rd St.
(c) Hospital or institution: Panama Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Panama (b) County
(c) City or town Los Santos
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Panama

3 (a) FULL NAME Francisco Garcia (FRANCISCO GARCIA)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife Single

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12 1928

8. AGE: Years	Months	Days	If less than one day
19	3	15	hr. min.

9. Birthplace Los Santos Panama
(Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name Manuel Garcia
13. Birthplace Panama

MOTHER
14. Maiden Name Carmen Mora
15. Birthplace Panama

16 (a) Informant MANUEL GARCIA MORA.
(b) Address Panama

17 (a) Cunal (b) Date thereof 8-29-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Sherwood Morgan & Co.
(b) Address 1018 W North Ave

AUG 29 1947 (Date rec'd by local registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28 1947, at 4:0 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 27 1947 to Aug 28 1947, and that I last saw h[illegible] alive on Aug 28 1947.

Immediate cause of death	Duration
Surgical Shock	
Due to CRUSH INJURY	
Due to	
Due to	
Other Conditions FOR ASTROCYTOMA OF CEREBELLUM-LEFT	

(Include pregnancy within 3 months of death)

Date of operation Aug. 28, 1947

Major findings of operation: ASTROCYTOMA OF LEFT CEREBELLUM

of autopsy: OPERATIVE WOUND

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John F. Hogan Jr. M. D.

Address Date signed

X

G54697 ✓ G54697

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINTING WITH PENCIL, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1108 Parah Ann st.
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1108 Parah Ann st.
(If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME Janet Alma Thomas

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: female
5. Color or race: colored
6 (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1.16.1933

8. AGE: Years 14 | Months 8 | Days 12 | If less than one day — hr. — min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Public School
11. Industry or business —

FATHER
12. Name Arzer Hill
13. Birthplace King William Co. Va

MOTHER
14. Maiden Name Elmma Thomas
15. Birthplace Baltimore, Md

16 (a) Informant Emma Thomas
(b) Address 1108 Parah Ann St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 2-47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location —

18 (a) Funeral director Samuel Astruc
(b) Address 1142 W Pratt St

19 (a) Aug 29 1947 (Date received by city registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1947 at 10:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8.25.47 to 8.28.47 and that I last saw h[illegible] alive on 8.28.47

Immediate cause of death: Pulmonary Tuberculosis — Duration: Feb. 1947
Due to —
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature James M. Cater M. D.
Address 400 N. Lemmon Date signed 8.29.47

VS 8

G54698 — BALTIMORE CITY HEALTH DEPARTMENT — G54698

CERTIFICATE OF DEATH

83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 930 Whitelock St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town insert RURAL and name town)
(d) Street No. 930 Whitelock St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Philip Glass
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Kate
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 65 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Abraham
13. Birthplace Austria

MOTHER
14. Maiden Name Freida
15. Birthplace Austria

16 (a) Informant Kate Glass
(b) Address 930 Whitelock St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-31-47 (month) (day) (year)
(c) Cemetery or crematory Woodmansonicle
Location Hebrew Mt Carmel

18 (a) Funeral director Jack Lewis Inc
(b) Address 460 Eutaw Place

19 (a) 8-29-1947 (Date rec'd by registrar) Hamilton Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-29-1947 at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-28 1947 to 8-29 1947 and that I last saw him alive on 8-28 1947

Immediate cause of death: Cerebral hemorrhage — Duration: 12 hrs.
Due to hypertension
Due to arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Daniel J. Schwartz
Daniel J. Schwartz, M. D. M. D.
Address 2320 Eutaw Pl. Date signed 8-29-47

VS 150

G54699 BALTIMORE CITY HEALTH DEPARTMENT ✓ G54699
Registered No.

CERTIFICATE OF DEATH 94a

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3630 Kimble Rd.
(c) Hospital or institution: 9 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3630 Kimble Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James S. Nelson, Jr. (SR)
3 (b) If veteran, name war
(c) Social Security Account No. 212-01-3845

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Emma L. Nelson (nee Eamer) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1882

8. AGE: Years	Months	Days	If less than one day
65	7	21	hr. min.

9. Birthplace Atlanta, Pa.
(Town, county, and state)

10. Usual Occupation
11. Industry or business Balto. American

FATHER
12. Name James M. Nelson
13. Birthplace Pa.

MOTHER
14. Maiden Name -- Keen
15. Birthplace Pa.

16 (a) Informant Mrs. Emma L. Nelson
(b) Address 3630 Kimble Rd.

17 (a) Burial (b) Date thereof 9/2/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

AUG 29 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 August 1947, at 11:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer Jr. M.D.
Medical Examiner.
Date signed 29 Aug. 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54700 ✓ G54700

BALTIMORE CITY HEALTH DEPARTMENT

G54700 CERTIFICATE OF DEATH 48 B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 948 Stoddard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 948 Stoddard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ida Brown (Spann)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Robert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19 1906

8. AGE: Years 41 | Months 4 | Days 9 | If less than one day hr. min.

9. Birthplace Manning, S. C. (Town, county and state)

10. Usual Occupation Unemployed.

11. Industry or business

FATHER 12. Name William Canty
13. Birthplace North Carolina

MOTHER 14. Maiden Name Alice Brown
15. Birthplace South Carolina

16 (a) Informant Graham Robert Brown
(b) Address 48 Stoddard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 2, 1947 (month) (day) (year)
(c) Cemetery or crematory National Cemetery
Location Frederick Avenue

18 (a) Funeral director [illegible]
(b) Address [illegible] Druid Hill

19 (a) [illegible] (b) [illegible]
(Date filed) (Registrar)
Sep 2 1947 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28, 19 47 at 5:30a M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 2 1947 to Aug 28 1947, and that I last saw her alive on Aug 27 1947

Immediate cause of death	Duration
Carcinoma of Uterus	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature O. D. Taylor
Address 522 Harlem Ave Date signed 8/28/47

X

G54170 D 87729

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G54170

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2922 E. Baltimore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Concordia

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 27 1947

8. AGE: Years | Months | Days: 2 | If less than one day: hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Victor Concordia
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Velma La Mana
15. Birthplace Baltimore Md.

16 (a) Informant Victor Concordia
(b) Address 2922 E. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 29 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

29 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG. 28, 1947, at 6:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from AUG. 28 1947 to AUG. 28, 1947, and that I last saw her alive on AUG. 28, 1947.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Prematurity	
Due to	
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irwin M. Krasnow M. D.
Address Sinai Hospital Date signed 8/29/47

CASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G54702 BALTIMORE CITY HEALTH DEPARTMENT ✓ G54702
Registered No.

CERTIFICATE OF DEATH 83a

Please fill all items. Any information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2326 Cambridge st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas [redacted] ZIEGEL

3 (b) If veteran, name war —
3 (c) Social Security Account No. 213-07-7842

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	WIDOWED

6 (b) Name of husband or wife MARY ZIEGEL
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 25, 1889

8. AGE: Years	Months	Days	If less than one day
58	1	3	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Mc North Packing Co.

FATHER
12. Name Michael Ziegel
13. Birthplace Germany

MOTHER
14. Maiden Name Lena Smigielska
15. Birthplace Germany

16 (a) Informant William J. Ziegel (Son)
(b) Address 727 S. Potomac St.

17 (a) Burial (b) Date thereof 8-29-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location German Hill Rd.

18 (a) Funeral director Charles L. Seiden
(b) Address 3605 Fait ave.

19 (a) 1947 (b) Washington Nilliams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28 1947, at 2 38 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to Its death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, spontaneous.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Reyer M.D.
Medical Examiner.
Date signed

VS 191

G54703 BALTIMORE CITY HEALTH DEPARTMENT ✓ G54703
Registered No.

CERTIFICATE OF DEATH 159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Pleasant Sts
(c) Hospital or institution: Mercy.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d.
(e) Length of stay in Baltimore (yrs., mos., or days) 2d.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5910 Smith Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Jane Darsey.

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-27-47

8. AGE: Years	Months	Days	If less than one day
—	—	2	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Parker E. Darsey.
13. Birthplace Louisville Ky.

MOTHER
14. Maiden Name Ethel Ottman
15. Birthplace Louisville Ky.

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 2/47 (month) (day) (year)
(c) Cemetery or crematory Calvary Cemetery
Location Louisville, Ky.

18 (a) Funeral director H. C. Mears & Son
(b) Address 505 W. Calvert St.

19 (a) Date received by registrar AUG 29 1947 (b) Signature Thurston Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-29. 1947, at 6.05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-27 1947 to 8-29 1947 and that I last saw her alive on 8-29 1947

Immediate cause of death Respiratory & circulatory collapse — Duration

Due to Prematurity. —

Due to 34 wk pregnancy. —

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John F. Ullsperger M. D.
Address Mercy Hosp. Date signed 7-29-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G54704 467

Registered No. G54704

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 302 Ridgemede road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore Ridgemede
(If outside city or town limits, write RURAL and give town)
(d) Street No. 302 Ridgemede road
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN J. McSWEENEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary Hund McSweeney
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) July 4, 1872

8. AGE: Years	Months	Days	If less than one day
75	1	23	hr. min.

9. Birthplace Marlboro, Mass. (Town, county, and state)
10. Usual Occupation Agent
11. Industry or business Mystic Steamship Co.

FATHER
12. Name John McSweeney
13. Birthplace Ireland

MOTHER
14. Maiden Name Crowley
15. Birthplace Ireland

16 (a) Informant Mrs. Mary Hund McSweeney
(b) Address 302 Ridgemede road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas J. Evans & Son
(b) Address 118 N. Mt Royal Ave

19 (a) Date received by registrar 29 1947 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27 19 47 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 15 August 1947 to 27 Aug 1947 and that I last saw h[illegible] alive on 27 August 1947

Immediate cause of death	Duration
Respiratory failure	
Due to Metastatic carcinoma	
Due to Carcinoma of lung and Adenocarcinoma of rectum	7 -
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 8 May 1941
Major findings of operation: Adenocarcinoma of rectum
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John A. Nesbit Jr. M. D.
Address 20 E. Preston St. Date signed 29 Aug 47

Batt. 2 X

G54705 BALTIMORE CITY HEALTH DEPARTMENT G54705
CERTIFICATE OF DEATH 94a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hampnett ave.
(c) Hospital or institution: Pine Ridge Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 45 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 418 Forrest
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME NICHOLAS MATTHEWS

3 (b) If veteran, name war
3 (c) Social Security Account No. 219-05-4285

4. Sex: Male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mabel Medford Matthews
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) June 27, 1890

8. AGE: Years 57 | Months 2 | Days 1 | If less than one day ... hr. ... min.

9. Birthplace Greece (Town, county, and state)
10. Usual Occupation Brewery Worker
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant George Matthews
(b) Address 418 Forrest street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/1/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location

18 (a) Funeral director J. Evans Sons Inc.
(b) Address 118 W. Mt. Royal Ave.

19 (a) 29 1947 (Date received by registrar) Washington Hollow Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28 19 47 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947 to 8/28 1947 and that I last saw him alive on 8/28 1947

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Delcarse Dalley M. D.
Address 703 Harford Ave Date signed 8/29/47

VS 150

G54706 Calvin

BALTIMORE CITY HEALTH DEPARTMENT ✓ G54706

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Ln.
(c) Hospital or institution:
Home For Aged Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Calvin Wallace

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	W.

6 (b) Name of husband or wife Mary Clapoadel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Dec. 12 1870

8. AGE: Years	Months	Days	If less than one day
76	8	16	hr. min.

9. Birthplace Rightsville Pa
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Wallace
13. Birthplace ?

MOTHER
14. Maiden Name Mary Budding
15. Birthplace ?

16 (a) Informant Estelle Linton
(b) Address 1200 Valley St

17 (a) Burial (b) Date thereof Aug 30 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Bela Weisfeld
(b) Address 900 East Biddle St

19 (a) (b)
(Date rec'd by registrar) Registrar

AUG 29 1947
VS 1947 Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 25 1947, at 11:50 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 18 1947, to Aug 28 1947, and that I last saw him alive on Aug 25 1947.

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Chronic Myocarditis	3 yrs
Due to	
Other Conditions Arter Sclerosis	10 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E. North Av Date signed 8/25/47

G54707

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G54707 Registered No. 186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 Hanover st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HARVEY R. SOUTH

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1908

8. AGE: Years 39 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Ga (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER: 12. Name; 13. Birthplace

MOTHER: 14. Maiden Name; 15. Birthplace

16 (a) Informant Hunter Owens
(b) Address La Grange Ga

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 29th 1947 (month) (day) (year)
(c) Cemetery or crematory
Location La Grange Ga

18 (a) Funeral director Leo S. Soake
(b) Address 701-03 N. Patterson Park ave

19 (a) (Date received by Registrar) AUG 30 1947 (b) Huntington Williamsville, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-27-1947 at 2 40 A.M.

21. I certify that I took charge of the remains described above, held an Inspection + Inq thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Fractured Skull
Intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 2/3

(a) Date of injury 8-27-47 at 2 30 A. M.
(b) Where did injury occur? 1704 Hanover St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fell off roof

23. Signature Geo. S. Merdel M.D. Medical Examiner.
Date signed 8/27/47

correct age is especially important. Physicians: please write the ... Every item of information should be carefully supp... CARBON PAPER, WITH ONE LEADING INK.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

158

G54708 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Boones Mill (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eleanor Thomas

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-7-39

8. AGE: Years 8 | Months 5 | Days 22 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Hillard Thomas
13. Birthplace Va.

MOTHER 14. Maiden Name Flora Bowman
15. Birthplace Va.

16 (a) Informant Relative
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug. 29-1947 (month) (day) (year)
(c) Cemetery or crematory
Location Roanoke, Va.

18 (a) Funeral director John O. Mitchell & Son
(b) Address 1906 Eutaw St. Balto. Md.

19 (a) (Date rec'd by registrar) (b) Registrar
AUG 29 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29 1947 at 7:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 17 1947 to Aug. 29 1947 and that I last saw h[illegible] alive on Aug. 29 1947

Immediate cause of death (a) Kidney failure — Duration
(b) Hypertension
(c) Cardiac failure
Due to (a) Lupus erythematosis
Due to (b)
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: not yet reported.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John D. Morris M. D.
Address Johns Hopkins Hosp. Date signed 29 Aug 47

~~G54709~~ ~~86570~~ G54709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

IN. 112888 Registered No. G54709

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2419 Barclay St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Solomon (Elaine

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 7th 1947

8. AGE: Years	Months	Days	If less than one day
		20	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Solomon
13. Birthplace Va.

MOTHER
14. Maiden Name Elaine Hinton
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave

17 (a) Cremation (b) Date thereof 8-28-47
(month) (day) (year)
(c) Crematory Baltimore City Hospitals
Location 4940 Eastern Ave (Records)

18 (a) Funeral director
(b) Address

19 (a) AUG 30 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27/1947 19..., at 8.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 9th 47 19..., to Aug. 27 19 47 and that I last saw her alive on Aug. 27th 19 47.

Immediate cause of death

Prematority - 1½ lbs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Prematority

Duration
20 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Julian P. Griffin M. D.
Address Balt. City Hosp. Date signed 28 Aug 1947

X

G54710

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1246

Registered No. G54710

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST
(c) Hospital or institution: ST. JOSEPH'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1518 EUTAW PLACE (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS LEO KELLY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife ANNA M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/24/01

8. AGE: Years	Months	Days	If less than one day
46	0	5	hr. min.

9. Birthplace BALTIMORE - MD. (Town, county, and state)
10. Usual Occupation BAR TENDER
11. Industry or business

FATHER
12. Name Frank P. Kelly
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary Fisher
15. Birthplace Montgomery County, Md.

16 (a) Informant Frank Kelly Jr.
(b) Address 513 E. 22nd Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/1/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md

18 (a) Funeral director H. Thos. Mears and Son
(b) Address 1600 Calvert St.

19 (a) AUG 30 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/29 1947, at 2:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/8 1947, to 8/29 1947, and that I last saw h[illegible] alive on 8/29 1947.

Immediate cause of death CIRRHOSIS OF LIVER — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation CIRRHOSIS OF LIVER

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry J. Houska M.D.
Address [illegible] Date signed 8/29/47

G54711

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No. G54711

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2319 Barclay St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2319 Barclay St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Herring

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	Married

6 (b) Name of husband or wife Laurence O. Herring
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1900

8. AGE: Years	Months	Days	If less than one day
47	6	22	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Brewer
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Charlotte Gildenny
15. Birthplace Baltimore, Md.

16 (a) Informant Charlotte Boy
(b) Address

17 (a) Burial (b) Date thereof 9-2-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodland Memorial Park
Location Taylor Ave.

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul St.

19 AUG 30 1947 (b) Huntington-Williamson, Md.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 29 1947, at 12 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1947 to Aug 29 1947, and that I last saw M. alive on Aug 28 1947.

Immediate cause of death	Duration
Cerebral Thrombosis	2 days
Due to Metastasis from	
Cancer of Uterus.	1 year
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edeath Worthington M. D.
Address 2706 St Paul St Date signed 8/29/47

G51712

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G51712

Every item of information should be carefully supplied. This correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dna
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 110 Chesapeake Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sidney a. Cross

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-12-0038

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) about 1869

8. AGE: Years	Months	Days	If less than one day
78			hr. min.

9. Birthplace Unknown
(Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Miss Mildred Perine
(b) Address 216 W Monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem
Location A. A. Co.

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St Baltimore, Md

19 (a) AUG 30 1947 (Date received by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1947 at 4:35 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Myocardial Degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Ryan M.D.
Medical Examiner
Date signed 8-29-47

G51713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G51713

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 119 N. Front St.
(c) Hospital or institution:
5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 119 N. Front St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Philip Becker

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/9/1905

8. AGE: Years 42 | Months 6 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Philip Becker
13. Birthplace Balto

MOTHER
14. Maiden Name Frances Rasocha
15. Birthplace Europe.

16 (a) Informant Mrs Frances Becker
(b) Address 119 N Front St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/2/47 (month) (day) (year)
(c) Cemetery or crematory London Park Cem
Location Balto.

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St Paul St

19 AUG 30 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1947, at 5:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture rt. femur
Osteomyelitis of rt. femur

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☒ cause of death, fill in the following:
(a) Date of injury 7-24-47 at ? 5/1 M.
(b) Where did injury occur? 1190 N. Front St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no
(d) Means of injury Fell & fractured femur

23. Signature George G. Mitchell M.D. Medical Examiner.
Date signed 8/28/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G51714

Moler

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G51714

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully handled. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Kelton Rd
(c) Hospital or institution: Ashburton Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) ~~State~~ Wash D.C. (b) County
(c) City or town Washington D.C.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 411-6th N.E. Wash D.C.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Moler

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~wife~~: Wm. Gr. Moler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 4, 1864

8. AGE: Years 83 | Months | Days 24 | If less than one day hr. min.

9. Birthplace Frederick Co Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Barnett
13. Birthplace Md

MOTHER
14. Maiden Name Don't know
15. Birthplace Germany

16 (a) Informant Jesse L. Jones
(b) Address 1920 Stend Pl

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 1, 47 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet
Location Frederick City Md

18 (a) Funeral director A. Howard Ebbens
(b) Address 411 N Charles St

19 (Date received by local registrar) AUG 30 1947 Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28, 1947, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1946 to Aug 28 1947 and that I last saw him alive on Aug 25 1947

Immediate cause of death: Myocardial Insufficiency

Due to

Due to

Other Conditions: Arteriosclerosis, Hypertension, Myocarditis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John G. Schwenck, M.D.
Address 1307 S. Charles St Date signed 8/29/47

G54715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122 B

Registered No. G54715

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 da's
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2223 Sulgrave Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Rev. O. C. S. Wallace~~ Rev. Cates Charles Symonds Wallace

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Helen Moore
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1856

8. AGE: Years	Months	Days	If less than one day
90	9	1	hr. min.

9. Birthplace Kings Co. Nova Scotia (Town, county, and state)
10. Usual Occupation Clergyman
11. Industry or business

FATHER
12. Name Wm. John Wallace
13. Birthplace Nova Scotia

MOTHER
14. Maiden Name Rachel L. Wittier
15. Birthplace Nova Scotia

16 (a) Informant Mr. O. C. S. WALLACE Jr.
(b) Address 14 Dufferin Rd. Montreal, CANADA

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mount Pleasant
Location Toronto, Canada.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 AUG 30 1947 (Date rec'd by registrar) Hunter for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 Aug 1947, at 2:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 20 Aug 1947 to 29 Aug 1947, and that I last saw him alive on 29 Aug 1947

Immediate cause of death Post. Op. Atelectasis — Duration
Due to Volvulus
Due to
Other Conditions Cardiac Decomp.
(Include pregnancy within 3 months of death)
Date of operation 24 Aug 47
Major findings of operation: Volvulus
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. A. Cerasano M. D.
Address Maryland Gen'l Hosp. Date signed 29 Aug 47

VS 150

G54716

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G54716

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2309 Ken Oak Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2309 Ken Oak Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Augusta Sasse

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation House duties.
11. Industry or business

FATHER
12. Name Unknown.
13. Birthplace

MOTHER
14. Maiden Name Unknown.
15. Birthplace

16 (a) Informant Dr. William Tarun
(b) Address 2309 Ken Oak Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Baltimore, Md.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

AUG 30 1947 (Date rec'd by registrar) (By) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 29 1947, at 5 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 31 1947, to Aug 29 1947, and that I last saw her alive on Aug 28 1947.

	Duration
Immediate cause of death: Coronary Thrombosis	12 hrs.
Due to: Coronary sclerosis.	?
Due to	
Other Conditions: Angina pectoris	2 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward F. Cotter M. D.
Address 11 E. Chase St. Date signed

Dr. Edw. F. Cotter X

G54717

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

G54717 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Oregon (b) County
(c) City or town Box 154 Wauna
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Bristow

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-18-34

8. AGE: Years	Months	Days	If less than one day
12.	9	11	hr. min.

9. Birthplace Oregon. (Town, County, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Russell Bristow
13. Birthplace ?

MOTHER 14. Maiden Name Myrtle Bates
15. Birthplace Wash.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 8/30/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Clatskanie
Location ~~Portland~~ Oregon

18 (a) Funeral director Ulgut Funeral Home
(b) Address Julian St

19 (a) AUG 30 1947 (b) Huntington Williams, Registrar, M.D.
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 29 - 1947, at 5.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June - 20 1947, to Aug - 29 1947, and that I last saw him alive on Aug - 29 1947.

Immediate cause of death Cardiac failure. — Duration

Due to Congenital heart disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. C. Childs M. D.
Address Johns Hopkins Hosp. Date signed 8-29

651718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 651718

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please correct age is especially important. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount Ave.
(c) Hospital or institution: Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 82
(e) Length of stay in Baltimore (yrs., mos., or days) 90 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City. (If outside city or town limits, write RURAL and give town)
(d) Street No. 223 W. Monument St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Williams Mrs. Martha

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife deceased

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5 1857

8. AGE: Years 90 | Months 5 | Days 24 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore City (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name John Thorpe
13. Birthplace Baltimore

MOTHER 14. Maiden Name Elizabeth Heath
15. Birthplace Baltimore

16 (a) Informant Miss Marian Reed
(b) Address 223 W. Monument St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 1 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director M. Cook Syfer
(b) Address 1600 N. Ave.

19 (a) AUG 30 1947 (Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1947 at 12:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8 June 1947 to 29 Aug 1947 and that I last saw her alive on 29 Aug 1947.

Immediate cause of death Cardiac failure — Duration

Due to Fracture right Femur - senile fracture — Duration

Due to Senility — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 11/3
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 6-7-47 at 3 PM
(c) Where did injury occur? 223 W. Monument St. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no
(e) Means of injury Slipped & fell to floor

23. Signature Kyle Moore, M.D.
Address Church Home & Hosp Date signed 8-29-47

Howard J. Mullen M.D. X

G54719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G54719 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 Park Heights Ave
(c) Hospital or institution: Mt. Sinai Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5006 Pimlico Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fahmie Sandler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late Abraham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years	Months	Days	If less than one day
79			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business None

FATHER
12. Name David Sandler
13. Birthplace Russia

MOTHER
14. Maiden Name Pauline ?
15. Birthplace Russia

16 (a) Informant Hymen Sandler
(b) Address 5006 Pimlico Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31, 1947 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Sol Levinson & Bros
18 (a) Funeral director 1124-1126 W North Ave
(b) Address

AUG 30 1947 (Registered by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 19 47 at 11.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 25 1939 to 8/28 1947 and that I last saw h[illegible] alive on 8/28 19 47.

Immediate cause of death	Duration
Acute Coronary Insufficiency	
Due to Coronary Sclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. L. Hornstein M. D.
Address 737 Asquith St Date signed 8/30/47

G54720

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G54720

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline St.
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34 days
(e) Length of stay in Baltimore (yrs., mos., or days) years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3725 Ellerslie Ave
(St Elizabeth (Institution)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mother M. Emerentiana (Crowley)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct. 20, 1879

8. AGE: Years	Months	Days	If less than one day
68	10	9	hr. min.

9. Birthplace M 286.
(Town, county, and state)

10. Usual Occupation Religious

11. Industry or business

FATHER
12. Name Patrick Crowley
13. Birthplace Co. Cavan Ireland

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Mother Mary Imelda
(b) Address 3725 Ellerslie Avenue

17 (a) Burial (b) Date thereof Sept 1 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Elizabeth's Home
Location Balto Md.

18 (a) Funeral director Henry McEnkins Sons Co
(b) Address McCulloh & Richard Sts

19 (Date rec'd by registrar) AUG 30 1947 Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29 1947 at 6:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/25/ 1947, to 8/29/ 1947 and that I last saw her alive on 8/29/ 1947.

Immediate cause of death	Duration
Cardio-Vascular Accident	
Due to Generalized Arteriosclerosis	
Due to	
Other Conditions Hypertensive Cardio-Vascular Disease	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry J. Houska M.D.
Address St. Jos. Hosp. Date signed 8/29/47

G54721 old# F74326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH · 13B

Registered No. G54721

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully inquired. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Road at Herring Run
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 724 N. Wolfe
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anita Brown

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24, 1943

8. AGE: Years	Months	Days	If less than one day
4	4	5	hr. min.

9. Birthplace Baltimore, Balt, Maryland (Town, county, and state)
10. Usual Occupation child
11. Industry or business

FATHER
12. Name Henry Brown, No. Carolina
13. Birthplace

MOTHER
14. Maiden Name Ethel Mayo
15. Birthplace No. Carolina

16 (a) Informant Mother
(b) Address 724 N. Wolfe

17 (a) Burial (b) Date thereof Aug 30, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location Anne Arundel County

18 (a) Funeral director Mrs. R. A. Elliott & daughter
(b) Address 1129 No. Carey

AUG 30 1947 Huntington Williams, M.D.
(Date rec'd by local registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1947, at 12 PM

21. I certify that death occurred on the date above stated; that I attended deceased from August 23 1947, to Aug 29 1947, and that I last saw h[illegible] alive on Aug 29 1947

Immediate cause of death	Duration
Tuberculous meningitis	6 days
Due to Miliary Tuberculosis	2 wks
Due to	
Other Conditions Tuberculosis, L. lung	over

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. Hall Lyerly M. D.
Address Sydenham Hosp. Date signed Aug 29, 1947

G54722

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G54722

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Gambrills
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy "A" Staples

3 (b) If veteran, name war

3 (c) Social Security Account No.

Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-27-47

8. AGE: Years	Months	Days	If less than one day
—	—	2	4 hr. — min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William E. Staples
13. Birthplace Md.

MOTHER 14. Maiden Name Ann Christensen
15. Birthplace So. Dakota

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 30/47 (month) (day) (year)

(c) Cemetery or crematory
Location Annapolis Md

18 (a) Funeral director B & T Hopkins & Son
(b) Address Annapolis Md

19 (a) Filed AUG 30 1947 (b) by Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-29-1947 at 1000 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-28-1947 to 8-29-1947 and that I last saw alive on 8-29 1947.

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A M Ellwood Jr M.D.
Address J H H Date signed 8-30

V S 150

G54723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

Registered No. G54723

Every item of information should be carefully supplied. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 806 N. Payson Street (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Benjamin Mason

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Martha Mason

6 (c) If alive, give age 26 years

7. Birth date of deceased (mo., day, yr.) 6/9/1919

8. AGE:	Years	Months	Days	If less than one day
	28	2	20	hr. min.

9. Birthplace Prestfield Co, Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Md Dry Dock

FATHER
12. Name Benjamin Mason
13. Birthplace Va

MOTHER
14. Maiden Name Nora Meade
15. Birthplace Va

16 (a) Informant Martha Mason
(b) Address 806 N. Payson St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/30/47 (month) (day) (year)

(c) Cemetery or crematory Location Prestfield Co, Va

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Ave

19 AUG 30 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29, 1947, at 11 a.m.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH: Gun shot wounds of the heart & lungs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8/29/47 at approx. 11:45 a.m.
(b) Where did injury occur? Harlem Ave. & Mount St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearms

23. Signature Howard J. Madison M.D. Medical Examiner.
Date signed 8/29/47

G54724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G54724

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1500 Eutaw Division St.
(c) Hospital or institution: Provident Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2106 Druid Hill Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Maude Pollard

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rev. Paul

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25, 1896

8. AGE: Years 51 | Months 1 | Days 1 | If less than one day hr. min.

9. Birthplace Halifax - Nova Scotia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Rev. Paul Pollard
(b) Address 2106 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 31, 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Cem.
Location Baltimore Co. Md.

18 (a) Funeral director Wm. Lee H. Hyland
(b) Address 1691 Druid Hill Ave

19 (a) AUG 30 1947 (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 26 1947, at 9:21 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 25, 1947, to Aug 26, 1947, and that I last saw h[illegible] alive on Aug. 26, 1947

Immediate cause of death	Duration
Cerebral hemorrhage	1 day
Due to Hemiplegia right side	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard Jones M. D.
Address 1131 Park Ave Date signed 8/30/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6547~~25~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 654725

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 517 S. Fulton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 517 S. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James W. Kelly

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 216-09-7002A

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Ella May Kelly
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1875

8. AGE: Years 71 | Months 9 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Moulder, Retired
11. Industry or business Caroline Iron Foundry

FATHER
12. Name James M. Kelly
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Rebecca Magness
15. Birthplace Annapolis, Md.

16 (a) Informant Mr. John J. Kelly
(b) Address 517 S. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 30/47 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore

18 (a) Funeral director Frederick A. Cole
(b) Address 200 W. Lombard St.

19 (a) AUG 30 19[illegible] (Date rec'd by registrar) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27, 1947, at 7:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/5 1945 to 8/27 1947 and that I last saw him alive on 8/27 1947

Immediate cause of death	Duration
Myocardial Degeneration	2 yrs (?)
Due to Arteriosclerosis	?
Due to B. Hemiplegia	3 days.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard E. Bryand
Address 1605 W. Balto. Date signed 8/28/47

X

G51726 G51726

BALTIMORE CITY HEALTH DEPARTMENT

BC# B87326 CERTIFICATE OF DEATH 159 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Randallstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. Allen Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Schwatka

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/26/47

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Lester F. Schwatka
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Thelma V. Green
15. Birthplace Baltimore Co, Md.

16 (a) Informant Mrs. Thelma Schwatka
(b) Address Randallstown, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) AUG 30 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/28 1947 at 5 3/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/26 1947, to 8/28 1947, and that I last saw him alive on 8/25 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Congenital Atelectasis	
Due to Prematurity	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stewart M. Williams M. D.
Address University Hospital Date signed 8/28/47

G54727

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G54727 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 54
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs. deceased

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2430 Guilford (If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country

3 (a) FULL NAME Lester Jones

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24 1890

8. AGE: Years	Months	Days	If less than one day
57	4 3	6	hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Lark Jones.
13. Birthplace North Carolina

MOTHER
14. Maiden Name Ala Baker.
15. Birthplace North Carolina

16 (a) Informant Brooks Jones.
(b) Address Rising Sun. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 3 1947 (month) (day) (year)
(c) Cemetery or crematory Crumpton
Location Crumpton M.C.

18 (a) Funeral director J.C. Tipton.
(b) Address Rising Sun Md.

19 (a) Date rec'd by registrar SEP 2 1947 Washington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 30 1947, at 8 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-6 1947 to 8-30 1947 and that I last saw h. living alive on 8-30 1947

Immediate cause of death	Duration
Cancer intestines	
Primary Base cause	
Undetermined	
Due to	
Due to	
Other Conditions Arteriosclerosis amputated leg.	

(Include pregnancy within 3 months of death)
Date of operation 7-7-47
Major findings of operation: arteriosclerosis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Classen M.D. M. D.
Address Date signed

G54728 430994 436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

39c

G54728 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. NOTE—DO NOT FOLD FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County.....
(c) City or town Woodbine, (If outside city or town limits, write RURAL and give town)
(d) Street No..... (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Addline Richardson ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 12-24-80

8. AGE: Years	Months	Days	If less than one day
67	8	7	..... hr. ..... min.

9. Birthplace Pa (Town, county and state)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name Clinton Dorsey

13. Birthplace Pa. ?

MOTHER 14. Maiden Name Rebecca Anderson

15. Birthplace Pa.

16 (a) Informant.....

(b) Address JOHNS HOPKINS HOSPITAL

17 (a)..... (Burial, cremation, or removal) (b) Date thereof..... (month) (day) (year)

(c) Cemetery or crematory Mt Olivet

Location Baltimore Md

18 (a) Funeral director W Howard Hoff

(b) Address 4201 Eastern Ave Balto Md

19 (a)..... (Date rec'd by registrar) Washington Williams M.D. Registrar

AUG 31 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-3- 1947 to 8-31 1947, and that I last saw her alive on 8-31 1947

Immediate cause of death	Duration
Cardiac failure	
Due to Rocky Mountain spotted fever	1 mo.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature W Rawlings M. D.

Address Johns Hopkins Hosp Date signed 8-31-47

A.J. Davies
800 W. 33rd St.

G54729

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G54729 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3502 Clifton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2726 Guilford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry F. Craig

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Catherine Craig
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1862

8. AGE: Years 85 | Months 0 | Days 18 | If less than one day hr. min.

9. Birthplace Princess, Maryland (Town, county, and state)

10. Usual Occupation Retired Railroad Conductor
11. Industry or business P. R. R.

FATHER
12. Name Henry Craig
13. Birthplace Cecil County, Md.

MOTHER
14. Maiden Name Martha Jackson
15. Birthplace Cecil County, Md.

16 (a) Informant Howard J. Craig
(b) Address 329 N. Eutaw St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-2-47 (month) (day) (year)
(c) Cemetery or crematory Loreland Memorial
Location Taylor Ave.

18 (a) Funeral director Wm. Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) 1947 (Date rec'd by registrar) (b) Clayton Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1947, at 10.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 25 1947, to Aug 28 1947, and that I last saw h alive on Aug. 28 1947.

Immediate cause of death	Duration
Myocardial Insufficiency	4 days
Due to Arterio Sclerosis	20 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur J. Davies M. D.
Address 800 W 33rd (11) Date signed 8-30-47

G54730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G54730
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mo General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 648 Washington Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Perina

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Carrie Perina

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 5 1896

8. AGE: Years 50 | Months 9 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business Federal Tin Co

FATHER 12. Name John S Perina

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Anna Fagan

15. Birthplace Baltimore Md

16 (a) Informant Anna A. French

(b) Address 700 Allendale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 3-47 (month) (day) (year)

(c) Cemetery or crematory U.S National

Location Frederick Road

18 (a) Funeral director William Cook Jr

(b) Address 1217 St Paul St

19 (a) (Date received by registrar) (b) Registrar

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/29 1947, at 1:25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Hes death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature [illegible] Poyer M.D. Medical Examiner.

Date signed 8/30/47

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WRITE PLAINLY, WITH UNFADING INK.

G54731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

G54731 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 905 Lake Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** LIBBY ~~Rabbi~~ Levenson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Jacob Harris

13. Birthplace Russia.

MOTHER 14. Maiden Name Sarah

15. Birthplace Russia

16 (a) Informant Husband

(b) Address

17 (a) Burial (b) Date thereof 8-31-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Hebrew Immobtyp
Location Balto & Conkling St

18 (a) Funeral director Jacob Levin Inc

(b) Address 2100 Eutaw Place

19 (a) 8-31-1947 (b) Register
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 Aug 1947, at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 22 Aug 1947 to 29 Aug 1947 and that I last saw h[illegible] alive on 29 Aug 1947.

Immediate cause of death — Duration

Cardio-Renal Failure

Due to Generalized Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Philip H. Lerman M. D.

Address Sinai Hospital Date signed 29 Aug 47

G51732

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G51732 Registered No. 94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3500 Copley Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 41
(e) Length of stay in Baltimore (yrs., mos., or days) 32yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 3500 Copley Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel Soltz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elsa

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 52 | Months | Days | If less than one day hr. min.

9. Birthplace Toronto Can (Town, county, and state)

10. Usual Occupation Moving Pictures

11. Industry or business

FATHER 12. Name Jacob

13. Birthplace Russia

MOTHER 14. Maiden Name Jennie

15. Birthplace Russia

16 (a) Informant Elsa Soltz

(b) Address 3500 Copley Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-2-47 (month) (day) (year)

(c) Cemetery or crematory Arlington

Location Rogers Ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 2100 Eutaw Place

AUG 31 1947 Torrington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-30- 1947 at 4A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1939 to 8-29 1947 and that I last saw h[illegible] alive on 8-29 1947.

Immediate cause of death: Acute Coronary Occlusion — Duration

Due to: Myocardial Infarction — Duration

Due to: Arteriosclerosis — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.

Address 733 Arnold St Date signed 8-30-47

X

G54733 BALTIMORE CITY HEALTH DEPARTMENT G54733
CERTIFICATE OF DEATH 50
Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood & Green Sts
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 32 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Hampstead
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa B. Folk

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	~~m~~ Married

6 (b) Name of husband or wife: George Folk
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3-1881

8. AGE: Years	Months	Days	If less than one day
66	5	27	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Alfred Hann
13. Birthplace Maryland

MOTHER
14. Maiden Name Catherine Stone
15. Birthplace Maryland

16 (a) Informant Mrs Carroll Theirt
(b) Address Hampstead Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-2-47 (month) (day) (year)
(c) Cemetery or crematory Hampstead
Location Hampstead, Md

18 (a) Funeral director Edw Shipley
(b) Address Hampstead Md

(Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 30 19 47 at 1830 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 19 47 to 19, and that I last saw her alive on Aug 30 19 47.

Immediate cause of death	Duration
Respiratory failure	
Due to Metastatic carcinoma with	
Due to involvement of cerebrum & right	1 week
Other Conditions lung	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. C. Duvall Jr. M.D. M. D.
Address Clinic Hosp. Date signed Aug 30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G54734 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 ColdSpring Lane
(c) Hospital or institution:
Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 13 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 Cold Spring Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marcus Jefferson Foster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Stella May Foster

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 8 1877

8. AGE: Years 70 | Months 7 | Days 22 | If less than one day hr. min.

9. Birthplace Bentonville Va
(Town, county, and state)

10. Usual Occupation Retired letter carrier

11. Industry or business U.S. Post Office

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Isabelle E. Grove
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 2 1947 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Martinsburg W Va

18 (a) Funeral director Harry Hillmacoy
(b) Address 4204 Redwood Ave

19 (a) Date rec'd by local registrar (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1947, at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 15 1947 to Aug 30 1947, and that I last saw him alive on Aug 29 1947.

Immediate cause of death	Duration
CHRONIC MYOCARDITIS	10 yrs.
Due to Generalized Arterio Sclerosis.	15 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mary R Keenan, M. D.
Address 3803 Edmondson Date signed 9/30/47

IDA BARTON

BALTIMORE CITY HEALTH DEPARTMENT

G54735

CERTIFICATE OF DEATH 1937

G54735 Registered No.

Every item of information should be carefully supplied. The space is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore C. Co.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3606 Chestnut Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Barton

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Fillson A. Barton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30-1866

8. AGE: Years 81 Months 3 Days 29 If less than one day hr. min.

9. Birthplace Baltimore Co. Maryland
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Jacob Cook

13. Birthplace Maryland

MOTHER 14. Maiden Name Martha Forts

15. Birthplace Maryland

16 (a) Informant A. R. Barton

(b) Address 3606 Chestnut Avenue

17 (a) Burial (b) Date thereof Sept. 1-1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Moreland Memorial Park

Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home

(b) Address 3631 Falls Road

AUG 21 1947 (Date filed by registrar) (b) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/29 1947, at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Dec death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature H. Williams M.D. (Medical Examiner.)

Date signed 8/29/47

G54736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G54736
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5408 Springlake Way (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine M. Morris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Widowed

6 (b) Name of husband or wife Patrick H. Morris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/16/77

8. AGE: Years	Months	Days	If less than one day
70	7	13	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation H. Wife
11. Industry or business

FATHER
12. Name Dullions Mannion
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Connelly
15. Birthplace Ireland

16 (a) Informant Mr James Morris
(b) Address 5408 Springlake Way

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/1/37 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location old Frederick Rd

18 (a) Funeral director P. J. Eglen & Sons
(b) Address 518 Light St.

19 (a) Date received AUG 31 1937 (b) Registrar Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27 1937, at 6:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 20 1937, to Aug 27 1937 and that I last saw h.e.r. alive on Aug. 27 1937.

Duration

Immediate cause of death Cardiac failure
Due to Hypertensive cardiovascular disease.
Due to
Other Conditions Chronic debilitation. Agranulocytosis.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul A. Mannion M. D.
Address Bon Secours Hosp. Date signed 8/29/37

G54737

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V122a

G54737

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd & Calvert st

(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3

(e) Length of stay in Baltimore (yrs., mos., or days) 3

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. Homewood Apartments, City 18 Md.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. ~~Joseph B.~~ Boyle, Helen G.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married,~~ widowed, ~~or divorced~~
Female	White	widowed

6 (b) Name of husband or wife Mr. Joseph B. Boyle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1895

8. AGE: Years	Months	Days	If less than one day
52	2	?	hr. min.

9. Birthplace New Jersey
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Triber
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Miss Foreman
15. Birthplace Pennsylvania

16 (a) Informant Mr. Howard Pierce

(b) Address

17 (a) Entombment (b) Date thereof 9/2/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lorraine Cem

Location Dundalk Ave. Road

18 (a) Funeral director John J. Baker Sons

(b) Address 818 Eight St.

19 (a) Date received 1947 (Local registrar) Washington Hollinsworth, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-30-47 19, at 8:37 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-27 1947 to 8-30 1947 and that I last saw her alive on 8-30- 1947

Immediate cause of death Cirrhosis of liver — Duration

Due to chronic Alcoholism

Due to

Other Conditions Sinus Brady
arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M.

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature [illegible] M. D.

Address Date signed

X

G54738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G54738

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 S. Bentalou St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 514 S. Bentalou St
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Hungary

3 (a) FULL NAME Elizabeth Molitor

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Michael Molitor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22-1858

8. AGE: Years	Months	Days	If less than one day
89	2	8	hr. min.

9. Birthplace Hungary
(Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Martin Molitor
(b) Address 514 S. Bentalou St

17 (a) Burial (b) Date thereof Sept 2-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto Md

18 (a) Funeral director B. Mbaker
(b) Address Pratt & Stricker Sts

19 (a) SEP 3 1947 (b)
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1947, at 12:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1947, to 8/30 1947, and that I last saw h[illegible] alive on 8/30 1947

Immediate cause of death	Duration
Arteriosclerotic cardiovascular disease	1 yr
Due to	
Due to	
Other Conditions Bronchopneumonia	1 wk

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin Miller M.D.
Address 1930 Wilkens Date signed 9/11/47

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54739

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G54739

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11da
(e) Length of stay in Baltimore (yrs., mos., or days) #

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Oakcrest.
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lewis Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1906

8. AGE: Years 41 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown (Patient unable to give information)
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/1/47 (month) (day) (year)
(c) Cemetery or crematory Beacon Chapel
Location Anne Arundel Co. Md.

18 (a) Funeral director W. Ridgely Selby
(b) Address 461 Washington Blvd.

19 (a) SEP 1 - 1947 (Date rec'd by registrar) (b)

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1947 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1947 to Aug 26 1947 and that I last saw h/ alive on Aug 26 1947.

Immediate cause of death	Duration
Septicemia	
Mediastinitis	
Due to tracheotomy	
Due to Tetanus	over
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. B. Hearne

Address Univ. Hosp. Date signed 8-26-47 M. D.

C. B. Hearne

G54740

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167

Registered No. G54740

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3¾ hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. C. (b) County
(c) City or town Laurinburg (If outside city or town limits, write RURAL and give town)
(d) Street No. Route 77 Box 18 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN W. Mc Lean

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/5/1924

8. AGE: Years 23 | Months 1 | Days 23 | If less than one day hr. min.

9. Birthplace Laurinburg N. C. (town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Alex Mc Lean

13. Birthplace N. C.

MOTHER 14. Maiden Name Mary Terry

15. Birthplace N. C.

16 (a) Informant Bill Mc Lean

(b) Address 1134 Penna Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/2/47 (month) (day) (year)

(c) Cemetery or crematory

Location Laurinburg N. C.

18 (a) Funeral director Elroy O. Wilson

(b) Address 1900 Brandywine Ave

19 (a) SEP 1 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1947, at 12:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Stab wound of neck with Lacer-Thoracic, left

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 8-27-47 at 8:00 P M (?)

(b) Where did injury occur? 800 Blk. Aiken St.

(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? no

(d) Means of injury Sharp Instrument

23. Signature Earl K. King M.D. (Medical Examiner)

Date signed 8-28-47

G54741

BALTIMORE CITY HEALTH DEPARTMENT

BC# b89305 CERTIFICATE OF DEATH 1579

Registered No. G54741

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County Balt.
(c) City or town Charlestown
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Baby Girl Eklund

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 28, 1947

8. AGE: Years	Months	Days	If less than one day
0	0	3	— hr. — min.

9. Birthplace Baltimore, Maryland
(Town, county and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Carl E. Eklund
13. Birthplace —

MOTHER
14. Maiden Name Vera Greswell
15. Birthplace Maryland

16 (a) Informant Father
(b) Address Charlestown, Md.

17 (a) Burial (b) Date thereof Sept. 1, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Crucifixo
Location Crucifixo Furnace, Md.

18 (a) Funeral director Wm. A. Pattison & Son
(b) Address Perryville, Md.

19 (a) SEP 1 - 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31 1947 at 2:9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 29 1947 to Aug 31 1947 and that I last saw her alive on Aug 31 1947.

Immediate cause of death	Duration
Intestinal Obstruction	
Due to Congenital Rectal Atresia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Aug. 29 1947
Major findings of operation: Intestinal Obstruction due to Congenital anal atresia
of autopsy: Intestinal Obst. - Meconium Ileus

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Katherine Sprunt M. D.
Address Union Memorial Hosp. Date signed 8-31-47

G54742

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G54742

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4001 Cold Spring Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 10
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4001 Cold Spring Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Karsh

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Aaron

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years 74 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Stella

13. Birthplace Russia

MOTHER 14. Maiden Name Rachael

15. Birthplace Russia

16 (a) Informant Mrs Rose Abrams

(b) Address 4001 Cold Spring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-47 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Phila Ld + Hamilton Ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 2166 Eutaw Place

19 SEP 1 - 1947 (Date rec'd by Registrar) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-1- 1947 at 6 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-15-46 19 to 9-1-47 19, and that I last saw h. alive on 9-1-47 19

Immediate cause of death: Edema

Due to: Malignancy (Cervix) Vulva

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration
2 days
1 yr

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature W J Baylin
Address 2040 Eutaw Date signed 9-1-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G54743

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2802 Winchester St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2802 Winchester St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAGGIE L. HILTNER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife George J. Hiltner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13, 1874

8. AGE: Years	Months	Days	If less than one day
73	7	16	hr. min.

9. Birthplace Carroll Co., Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Lewis Redding
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary Shambaugh
15. Birthplace Pa.

16 (a) Informant Mr. George J. Hiltner
(b) Address 6221 Liberty Rd.

17 (a) Burial (b) Date thereof 9/1/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 1 - 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29, 1947, at 5:45p M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 25 1947 to Aug 29 1947, and that I last saw h she alive on Aug 29 1947.

Immediate cause of death	Duration
Coronary Thrombosis	4/25/47
Due to	
Chr. Myocarditis	1942
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature
Address 1663 W Fort Ave Date signed 8/30/47

G54744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1938

G54744 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3117 Normount Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 3117 Normount Ave. (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EMILY G. LANG

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife John L. Lang
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 17, 1868

8. AGE: Years	Months	Days	If less than one day
79	2	12	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Theisz
13. Birthplace Germany

MOTHER
14. Maiden Name - Mettee
15. Birthplace

16 (a) Informant Mrs. Margaret McCollister
(b) Address 3111 Normount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/1/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 1 1947 (Date received by registrar) (b) Huntington Mitchell Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29, 1947, at 1:00pM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-29 1947, to 8-29 1947, and that I last saw her alive on 8-29 1947.

Immediate cause of death	Duration
Arteriosclerotic Heart Disease	7 yrs
Acute Congestive Heart Failure	3 days
Due to	
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Leon Aschman M. D.
Address 120 Poplar Grove St Date signed 8-30 47

X

G51715 BURKER G51715

BALTIMORE CITY HEALTH DEPARTMENT Registered No.

CERTIFICATE OF DEATH ✓ 95B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St. & Linden Ave.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo 28 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Baltimore
(c) City or town Baltimore Pikesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7006 Alden Road #8
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Irene Ada Bunker

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife A. Lee Bunker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7 Dec 1899

8. AGE: Years	Months	Days	If less than one day
47	8	22	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Ricker
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Elizabeth Snowden
15. Birthplace Baltimore

16 (a) Informant Mr. A. Lee Burker
(b) Address 7006 Alden Rd., Pikesville, Md

17 (a) Burial (b) Date thereof 9/2/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 1 - 1947 (b) Clayton Wilt Registrar
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 Aug 1947, at 1030 M

21. I certify that death occurred on the date above stated; that I attended deceased from 17 Apr 1947, to 29 Aug 1947, and that I last saw h[er] alive on 29 Aug 1947.

	Duration
Immediate cause of death: Circulatory failure	5 months
Due to: Rheumatic heart disease	15 yrs.
Due to: Rheumatism fever	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Allan Smith M. D.
Address Md. Gen. Hosp. Date signed 29 Aug. 47

X

G54746

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G54746

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 304 E 31st St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 304 E 31st St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Schmidt.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Emma Schmidt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29th, 1875

8. AGE: Years 70 91 | Months 11 | Days 1 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business Eastman Kodak Co.

FATHER
12. Name Herman Schmidt
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Sieling
15. Birthplace Germany

16 (a) Informant Mrs. Wm. H. Schmidt
(b) Address 304 E. 31st St.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 9/2/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Rd.

19 SEP 1 - 1947 (Date Rec'd by Registrar) (Written) Courtington for Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/30 1947, at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Lockwood M.D. (Medical Examiner)
Date signed 9/2/47

G54747

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓83a

G54747 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4220 Spring wood Ave.
(c) Hospital or institution: 261
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 77 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore 6
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4220 Spring wood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Catherine Becker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widowed

6 (b) Name of husband or wife William A. Becker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 12, 1869

8. AGE: Years	Months	Days	If less than one day
77	8	18	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Leonard Baumer
13. Birthplace Germany

MOTHER
14. Maiden Name Geizer
15. Birthplace N.Y.

16 (a) Informant Miss Ruth R. Becker
(b) Address 4220 Springwood Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 9/2/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. North Ave.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Rd.

19 (a) SEP 1 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30 1947, at 5 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1947, to Aug 30 1947, and that I last saw her alive on Aug 29 P.M. 47.

Immediate cause of death	Duration
Cerebral Hemorrhage	60 hrs.
Due to Arteriosclerosis	many yrs.
Due to	
Other Conditions Hemoplegia, left	9 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Max R. English M. D.
Address Date signed

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54748 BC# B85532 BRUSCOLINI

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1198

Registered No. G54748

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline St.
(c) Hospital or institution: St Josephs Hospital. 10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore #2 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1117 Forest St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country YES

3 (a) FULL NAME Genivieve E. Bruscolini. ✓

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Child.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1947

8. AGE: Years 0 | Months 0 | Days 29 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name NILLIO A. BRUSCOLINI
13. Birthplace ITALY

MOTHER
14. Maiden Name GENEVIEVE E. STAHL
15. Birthplace BALTO. MD.

16 (a) Informant GENEVIEVE E. BRUSCOLINI
(b) Address 7126 RIVER DRIVE RD. LYNCH POINT BALTO. CO.

17 (a) CREMATION (Burial, cremation, or removal) (b) Date thereof SEPT. 1, 1947 (month) (day) (year)
(c) Cemetery or crematory GREENMOUNT
Location GREENMOUNT AVE. BALTO.

18 (a) Funeral director Walter Burke Bradley
(b) Address 1922 W. North Avenue

19 (a) SEP 1 - 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1947, at 4:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 21 1947, to Aug 30 1947, and that I last saw him alive on Aug 30-1947.

Immediate cause of death	Duration
Cardio-Respiratory failure.	
Due to Toxemia of pregnancy	
Due to to death of the Newborn.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Ulcerations of cervix in gastro-intestinal tract & peritoneum.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John B Wells M.D.
Address St Jos Hosp Date signed 8-31-47

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C54749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 73a

Registered No. C54749

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rutland + Maryland
(c) Hospital or institution:
Sinai Hospital 1-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 105 South Robinson St.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Annie Wyatt

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: William Wyatt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 23, 1885

8. AGE: Years 62 | Months 7 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Industry

FATHER
12. Name Bartholemew Barrett
13. Birthplace ?

MOTHER
14. Maiden Name Mary Ellen Flynn
15. Birthplace ?

16 (a) Informant Cebely Di Carlo
(b) Address 105 South Robinson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-2-1947 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 1030 W. Fayette St.

19 (a) SEP 1 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Address

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/30 1947, at 10:34 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/29 1947 to 8/30 1947 and that I last saw he alive on 8/30 1947.

Immediate cause of death Pneumonia — Duration 3 hrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature K.E. Cohnberg M.D.
M. D.
Address Sinai Hosp. Date signed 8/31/47

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

054750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1138

Registered No. 054750

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2745 Beryl Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2745 Beryl Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No) X
If yes, name country

3 (a) FULL NAME Lawrence E. Barrett

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anna McKenna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31, 1891

8. AGE: Years	Months	Days	If less than one day
56	7	0	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Crane Operator
11. Industry or business Industry

FATHER
12. Name James T. Barrett
13. Birthplace Washington D.C.

MOTHER
14. Maiden Name Elizabeth Perkins
15. Birthplace Washington D/C.

16 (a) Informant Anna Barrett
(b) Address 2745 Beryl Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 3 (month) (day) 147 (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Avenue

18 (a) Funeral director Lloyd Kellerstrass
(b) Address 403 South Wolfe Street

19 (a) SEP 1 1947 (Date rec'd by registrar) (b) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/30 1947 at 6.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/4 1947 to 8/30 1947, and that I last saw h[illegible] alive on 8/30 1947

Immediate cause of death	Duration
Pulmonary Tuberculosis	5 yrs
Due to	
Due to	
Other Conditions	2 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 939 [illegible] Date signed

SIKORSKY X

G54751 B Cert # 618664

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

577

Registered No. G54751

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light St
(c) Hospital or institution: South Balto. Gen. Hosp 23-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1410 S. Hanover St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Dougherty

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 11, 1945

8. AGE: Years	Months	Days	If less than one day
2	6	19	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER
12. Name Sherwood Dougherty
13. Birthplace Balto

MOTHER
14. Maiden Name Anna May Jacobs
15. Birthplace Balto

16 (a) Informant mother
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-2-1947 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Ft. A. Co. Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1400 N Light St.

19 (a) Date rec'd by registrar (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1947, at 7:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 27 1947, to Aug 30 1947, and that I last saw h[illegible] alive on Aug 30 1947

Immediate cause of death	Duration
? Brain tumor	?
Due to type unknown	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harold Killam M. D.
Address Sr. Balto Gen Hosp Date signed 8-30-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54752 B-81420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G54752

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 minute
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 445 E Gittings St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE EDWARD WILLIAMS JR.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16 1947

8. AGE: Years	Months	Days	If less than one day
0	2	15	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER 12. Name George Williams
13. Birthplace Alabama

MOTHER 14. Maiden Name Margaret J. Bennett
15. Birthplace Boston

16 (a) Informant Mother
(b) Address 445 E Gittings St.

17 (a) Burial (b) Date thereof Aug 3 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd

18 (a) Funeral director Mark NE Dippel
(b) Address 355 E Lafayette

AUG 4 1947 (Huntington Ave Baltimore, Md.)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 3 1947 at 12 15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 31 1947 to Aug 31 1947 and that I last saw h[illegible] alive on Dead when seen

Immediate cause of death	Duration
Respiratory failure	0
Due to Pneumonia	1 day
Due to Pertussis	2 wks.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Dillon M. D.
Address So Balto. Gen Hosp Date signed 8-3-47

VS 150

TIMMERMAN

G54753

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45F

Registered No. G54753

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1123 N. Montford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1123 N. Montford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick B. Timmerman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Angela Timmerman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 8 1865

8. AGE: Years 82 | Months 3 | Days 22 | If less than one day: hr. min.

9. Birthplace: Balto. Co. Md. (Town, county, and state)

10. Usual Occupation: Retired - Tailor

11. Industry or business

FATHER
12. Name: Henry Timmerman
13. Birthplace: Balto. Co. Md.

MOTHER
14. Maiden Name: Unknown
15. Birthplace: "

16 (a) Informant: Mrs Bertha E. Parr
(b) Address 1123 N. Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-2-47 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Road

18 (a) Funeral director: John F. Miller Sons
(b) Address 2435 E. Oliver St

19 Sept 1 1947 Huntington Williams (Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-30-1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 30 July 1947 to 30 August 1947, and that I last saw h. alive on 29 Aug 1947.

Immediate cause of death	Duration
Bronchial pneumonia	2 days
Due to: Arteriosclerosis, Cardiovascular	
Due to:	
Other Conditions: Pharyngeal Carcinoma	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Howard Jackson M.D.

Address 1513 N. Milton Ave Date signed 1 Sept 47

G54754

GReeley

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46.E

G54754 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secour Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 24 dy
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 510 N. Kingwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM M. GREELEY

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-12-8504

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Catherine A. Greeley

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) July 9 1880

8. AGE: Years 67 | Months 1 | Days 25 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county and state)

10. Usual Occupation Tug Boat - Captain

11. Industry or business

FATHER
12. Name Patrick Greeley
13. Birthplace Ireland

MOTHER
14. Maiden Name Julia Goldie
15. Birthplace Ireland

16 (a) Informant Mrs Catherine A. Greeley
(b) Address 510 N. Kingwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-3-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director John E. Mullinix
(b) Address 2423 E Oliver St

19 (a) SEP 1 - 1947 (Date rec'd by registrar) (b) Huntington Ave Baltimore Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 31 1947 at 6 20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 7 1947 to Aug. 31 1947 and that I last saw him alive on Aug. 31 1947.

Immediate cause of death Carcinoma of transverse Colon & Metastases to small intestine. — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation July 21, 1947

Major findings of operation: Ca. of transverse colon & metastasis to small int.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph R Liberto M. D.
Address Bon Secour Hosp. Date signed 8/31/47

X

G54755

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G51755

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2491 Fairway; Dundalk (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George A. Grieb

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Marge E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1912

8. AGE: Years	Months	Days	If less than one day
35	1	23	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Engineer's Asst.
11. Industry or business Standard Oil Co

FATHER
12. Name Frank H. Grieb
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Anna Patzwald
15. Birthplace Balto. Md.

16 (a) Informant Mary E. Grieb
(b) Address 2497 Fairway Dund

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-2-47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Mem.
Location Germans Hill Rd. Md.

18 (a) Funeral director Labadee S. Zeiler
(b) Address 3405 Foist Ave.

19 (a) SEP 1 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-29- 1947, at 2-35 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Drowning

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 26/6
(a) Date of injury 8-29-47 at 2-30 P. M.
(b) Where did injury occur? Harbor at Standard Oil Co.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes.
(d) Means of injury Fell overboard Found drowned.

23. Signature Howard J. Madeira M.D. Medical Examiner.
Date signed 8-30-47

C54756

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1942

Registered No. C54756

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Diff
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 625 E 41st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carroll B. Baker

3 (b) If veteran, name war: World War II
3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Viola L. Baker (nee Lavezza
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 8, 1904

8. AGE: Years	Months	Days	If less than one day
43	6	23	hr. min.

9. Birthplace: Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: John W. Baker
13. Birthplace: Carroll Co., Md.

MOTHER
14. Maiden Name: Mary I. Carroll
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. Viola L. Baker
(b) Address: 625 E. 41st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/47 (month) (day) (year)
(c) Cemetery or crematory: Cedar Hill Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) SEP 1 - 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31 1942, at 5 30 M

21. I certify that I took charge of the remains described above, held an Inq Exclusive thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Occlusion

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Huntington Williams M.D.
Medical Examiner.
Date signed Aug 31, 1942

X

G54757

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G54757

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Reliance & Jones St.
(c) Hospital or institution: University Hospital 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1342 James St.
(If rural give location)
(e) Citizen of foreign country? ... (Yes or No)
If yes, name country ...

3 (a) FULL NAME Sarah J. Langeluttig
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Godfrey Langeluttig
6 (c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) July 2, 1875

8. AGE: Years	Months	Days	If less than one day
72	1	28	... hr. ... min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Benjamin Fisher
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Sarah Zimmerman
15. Birthplace Balto., Md.

16 (a) Informant Mr. Edwin Langeluttig
(b) Address 806 N. Augusta Ave.

17 (a) Burial (b) Date thereof 9/3/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 1 - 1947 (b) Huntington Williams
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30 1947, at 8:37 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/30 1947, to 8/30 1947, and that I last saw h~~e~~r alive on 8/30 1947.

Immediate cause of death	Duration
Respiratory and Circulatory Collapse	
Due to Cerebro Vascular Accident (Coronary) Thrombosis	
Due to Hypertension Arter. - Vascular disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation ...
Major findings of operation: ...
of autopsy: ...

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ...
(b) Date of occurrence ... at ... M
(c) Where did injury occur? ...
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work? ...
(Specify type of place)
(e) Means of injury ...

23. Signature Sidney N. Packer M. D.
Address University Hospital Date signed 8/31/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered, and the correct answer written. Physicians: please write the causes of death clearly and legibly. Underline the cause to which death should be charged statistically. Special attention is especially important.

G54758

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G54758

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 407 Mt. Holly St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 y
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 407 Mt. Holly St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LAURA CROSBY

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16, 1867

8. AGE: Years 80 | Months 1 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name George W. Crosby
13. Birthplace Balto.

MOTHER
14. Maiden Name Sarah A. Trine
15. Birthplace Balto.

16 (a) Informant Miss Elizabeth S. Crosby
(b) Address 407 Mt. Holly St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/3/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

SEP 1 1947

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1, 1947, at 1:55a M

21. I certify that death occurred on the date above stated; that I attended deceased from May 12 1947 to Sept. 1 1947 and that I last saw h[illegible] alive on Aug 31 1947.

Immediate cause of death	Duration
Cardio. Vascular-Hypertensive disease	5 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Thomas A. Todd, M. D.
Address 2108 St Paul St Date signed 9/1/47

X

C51759

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C51759

CWK-118343

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 80 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3908 Foster Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Edward Kreutzer

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Nellie (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21-1867

8. AGE: Years	Months	Days	If less than one day
80	4	9	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John E. Kreutzer
13. Birthplace Germany

MOTHER
14. Maiden Name Helen Heidenkemper
15. Birthplace Germany

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 2 1947 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison St.

19 (Date received by registrar) SEP 1 1947 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 19 47, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 26 19 47, to Aug. 30 19 47, and that I last saw him alive on Aug. 30 1947.

Immediate cause of death: Cardiac failure — Duration
Due to: Arteriosclerotic C-V Disease
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William H. Kreutzer M. D.
Address Balto. City Hosp. Date signed 30 Aug 47

G51760

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8 3a

G51760 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 721 N. Fremont Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 721 N. Fremont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sallie Beaver

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years	Months	Days	If less than one day
78			hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Elroy O. Wilson
(b) Address 1000 Brantly Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/2/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location

18 (a) Funeral director Elroy B. Wilson
(b) Address 1000 Brantly Ave.

SEP 2 1947 (Date rec'd by registrar) Hamilton for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH aug 29 19 , at 5 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/24 19 47 to 8/29 19 47 and that I last saw h[illegible] alive on 8/29/47

Immediate cause of death — Duration
Cerebral Hemorrhage
Due to
Due to Hypertension
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation None
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1131 Harlem Date signed 9/1/47

G51761 8-9M 45 32-5

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G54761 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 W. Lexington St
(c) Hospital or institution: Aged Women's Home 19-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christine K. Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	W.

6 (b) Name of husband or wife George

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 3 - 863

8. AGE: Years	Months	Days	If less than one day
84	4	27	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Alexander Goldsborough ?
13. Birthplace

MOTHER 14. Maiden Name Mary R. Clark ?
15. Birthplace

16 (a) Informant Aged Women's / Aged Men's Homes
(b) Address 1400 W. Lexington St

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof [redacted] 9-2-47 (month) (day) (year)
(c) Cemetery or crematory MT. OLIVET
Location BALTIMORE, MD.

18 (a) Funeral director WILLIAM COOK INC
(b) Address 1217 ST. PAUL ST.

SEP 2 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 30 1947, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 3rd 1947 to Aug 30 1947 and that I last saw her alive on August 26 1947

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to Myocardial Insufficiency with Pulmonary Edema	
Due to Arteriosclerotic Heart Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maryland Edward Day M. D.
Address 4-E-33d St Date signed Aug 31, 47

DR L. L. JACOBS 1700 EUTAW PLACE

C51762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V131a

Registered No. C51762

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully compiled. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 EUTAW PLACE
(c) Hospital or institution: Jerkins Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2300 MT. ROYAL TERRACE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH F. LIPP

3 (b) If veteran, name war	3 (c) Social Security Account No.
NONE	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife AGNES A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 7, 1869

8. AGE: Years	Months	Days	If less than one day
78	4	29	hr. min.

9. Birthplace BALTO. Md.
(Town, county, and state)
10. Usual Occupation SHOE SALESMAN
11. Industry or business RETIRED

FATHER
12. Name FRANCIS X. LIPP
13. Birthplace MARYLAND

MOTHER
14. Maiden Name LAURA GETTY
15. Birthplace MARYLAND

16 (a) Informant WALTER J. LIPP
(b) Address 308 RADNOR AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT 2, 1947 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location BALTO. Md.

18 (a) Funeral director WILLIAM COOK, INC
(b) Address 1217 ST. PAUL ST

19 (a) SEP 2 1947 (Date rec'd by Registrar) Huntington Williams, M.D.

VS 150 [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30 1947, at 11:07 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 16 1947 to Aug. 30 1947, and that I last saw h[illegible] alive on Aug. 30 - 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Ter. adv. C.V. (cardio-vascular) disease	
Due to Adv. Atherosclerosis	
Other Conditions Nephritis - Dis. of Liver	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis J. Jacobs M. D.
Address 1700 Eutaw Pl Date signed Aug. 30-47

93 August

G54763

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

Registered No. G54763

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland — 1400 Cayden Ct.

(b) Street address — St Joseph's Hospital

(c) Hospital or institution — Balto. Md. 21

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Balto.

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1515 Bush St. (If rural give location)

(e) Citizen of foreign country? Nun. (Yes or No)

If yes, name country

3 (a) FULL NAME Flossie M. Diffendall.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Andrew

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 29 1896

8. AGE: Years 51 | Months 5 | Days 2 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name George R. Parks

13. Birthplace Nebraska

MOTHER

14. Maiden Name Annie L. Mills

15. Birthplace Baltimore Md.

16 (a) Informant Andrew Diffendall

(b) Address 1516 Bush St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 3 1947 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet

Location Frederick Road

18 (a) Funeral director Wm. Cook Sons

(b) Address 1217 St. Paul St.

19 (c) Date rec'd SEP 2 1947 Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1 1947, at 12:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 13 1947 to Sept 1 1947, and that I last saw h[illegible] alive on Sept 1 1947.

Immediate cause of death	Duration
Cardio-Respiratory failure.	
Due to Congestive Heart failure.	
Due to Mitral & Aortic Stenosis &	
Other Conditions Rheumatic fever.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy AORTIC STENOSIS INSUFFICIENCY

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Harry G. Porter M. D.

Address [illegible] Date signed 9/4/47

G54764

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124a

G54764 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Typewrite or write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green Sts.
(c) Hospital or institution: University Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3612 Liberty Hgts. Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Flora MacCrowe

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, ~~widowed~~, or divorced Wd.

6 (b) Name of husband or wife Albert E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 31 1888

8. AGE: Years 59 | Months 5 | Days 0 | If less than one day hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Elmer E. Keller
FATHER 13. Birthplace Pa.

MOTHER 14. Maiden Name Margaret Landis
MOTHER 15. Birthplace Pa

16 (a) Informant Henry M Siegel
(b) Address 408 Munsey Bldg

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-3-47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem
Location Balto Co.

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St

SEP 2 1947 (Date rec'd by registrar) Huntington Williams Mgr

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/31 1947 at 4:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/31 1947 to 8/31 1947 and that I last saw her alive on 8/31 1947.

Immediate cause of death Status Lymphaticus — Duration

Due to Malignancy

Due to cirrhosis of liver; chronic alcoholism

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. J. Matthews M.D.
Address Univ. Hosp. Date signed 8/31/47

G54765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G54765

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1321 Pontiac Ave - 25

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25

(e) Length of stay in Baltimore (yrs., mos., or days) 1 1/2 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore - 25

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1321 Pontiac Ave

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Anna Belle Stull

3 (b) If veteran, name war

3 (c) Social Security Account No. 160-20-4422

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Married

6 (b) Name of husband or wife Shriner A. Stull

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 14-1887

8. AGE: Years	Months	Days	If less than one day
60	-	- 17	hr. min.

9. Birthplace Barbour Co West Virginia

(Town, county, and state)

10. Usual Occupation Parts Handler

11. Industry or business Bell Porcelain Stell Co

FATHER

12. Name W. Oveal

13. Birthplace W. Va

MOTHER

14. Maiden Name Unknown

15. Birthplace W. Va

16 (a) Informant Mina W. Stull

(b) Address 3826 Fairhaven Ave - 21

17 (a) Burial (b) Date thereof Sept 4-47

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Nester Cemetery

Location Tucker County W. Va.

18 (a) Funeral director Milton Schilling

(b) Address 3914 Hanover B K-25-

(c) SEP 2 1947 Huntington Williams M.D.

(Date received) (Local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1 - 19 47 at 12:12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 47 to 9/1 19 47 and that I last saw h[illegible] alive on 9/1 19 47

Immediate cause of death Cardiac Failure

Due to hypertensive cardio vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature James N. Ciano M. D.

Address 300 Patapsco St Date signed 9/1/47

G54766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G54766 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument Ave
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2121 Linden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gittel Maizlish

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Benjamin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Yeshia
13. Birthplace Russia

MOTHER
14. Maiden Name Fuga
15. Birthplace Russia

16 (a) Informant Benjamin Maizlish
(b) Address 2121 Lindenave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-2-47 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Herring Park

18 (a) Funeral director Jack Rentz Inc
(b) Address 2400 Eutaw Place

SEP 2 1947 (Date rec'd by Registrar) Huntington Williams M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/1/1947 at 9:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/24/47 1947 to 9/1/1947, and that I last saw her alive on 8/31/1947.

Immediate cause of death	Duration
CARCINOMATOSIS	
OBSTRUCTIVE JAUNDICE	
Due to MALIGNANCY of Stomach	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Norman Martin M. D.
Address Sinai Hosp. Balt. Date signed 9/1/47

X

G51767

CWK-113272

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

G51767

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 31 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 558 Mosher Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Washington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife William (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June ? 1896

8. AGE: Years ? 51 | Months 2 | Days | If less than one day ... hr. ... min.

9. Birthplace South Carolina
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Samuel Mosley
13. Birthplace South Carolina

MOTHER
14. Maiden Name Mary Lynn
15. Birthplace South Carolina

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/3/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

SEP (2) 1947 (Date received by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH August 29 1947, at 6:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 23 1947, to Aug. 29 1947, and that I last saw her alive on Aug. 29 1947.

Immediate cause of death	Duration
Miliary tuberculosis	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Above + old gastric ulcer

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard T. Binford M. D.

Address Balt. City Hosp. Date signed 8-31-47

X

51768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G51768
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: D.O.A.
(a) Baltimore City, Maryland
(b) Street address 1030 Stockton St
(c) Hospital or institution:
16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1030 Stockton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosie Carter.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 12, 1894

8. AGE: Years	Months	Days	If less than one day
52.	8	19	hr. min.

9. Birthplace Reedville Va
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Mary Carter
15. Birthplace Va

16 (a) Informant Leon Penfield
(b) Address 1030 N Stockton St

17 (a) Burial (b) Date thereof 9/3/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Co Md
18 (a) Funeral director Isaiah L Bennett
(b) Address 108 W Monument St

SEP 2 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/31 1947 at 4:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic myocardial degeneration
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Goldsmith M.D.
Medical Examiner.
Date signed 9/3/47

G51769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G51769

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1220 W. Mosher
(c) Hospital or institution: .16.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1220 Mosher (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Allen Cole

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W

6 (b) Name of husband or wife Alexander
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-18-64

8. AGE: Years	Months	Days	If less than one day
83	4	13	hr. min.

9. Birthplace Appomattox Va. (Town, county, and state)
10. Usual Occupation unemployed
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace " " "

MOTHER
14. Maiden Name Unknown
15. Birthplace " " "

16 (a) Informant Elouise Burke
(b) Address 1220 Mosher St.

17 (a) B (Burial, cremation, or removal) (b) Date thereof 9-3-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location City

18 (a) Funeral director Samuel W. Sullivan & Son
(b) Address 1011 E. Pratt & Arlington Ave. Baltimore, Md.

19 (a) SEP 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

V S-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31 1947 at 4:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 27 1947 to Aug 31 1947 and that I last saw h.e.r alive on Aug 27 1947.

Immediate cause of death	Duration
Chronic Cardio Vascular Disease	5 yrs.
Due to Cerebral Hemorrhage	8/31/47
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature E. Wallace Frey M.D.
Address 1928 Penna Ave Date signed 9/1/47

X

G51770

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G51770

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2518 N. Howard St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2518 N. Howard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H A Cephas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	W.

6 (b) Name of husband or wife Fannie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10 - 1879

8. AGE: Years	Months	Days	If less than one day
67 68	10	21	hr. min.

9. Birthplace Vienna Md.
(Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business

FATHER
12. Name William J. Cephas
13. Birthplace Md.

MOTHER
14. Maiden Name Amelia Thomas
15. Birthplace Md.

16 (a) Informant Amelia Woolford Davis
(b) Address 2518 Howard St

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 9-4-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Balto. Co.

18 (a) Funeral director Samuel W. Sullivan Jr.
(b) Address 1011 N. Arlington Ave

SEP 2 1947 (Date rec'd by registrar) (b) Huntington for Williams M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31 1947, at 7:45 M.

21. I certify that I took charge of the remains described above, held an Aug Ex Insp thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Helfrich M.D.
Medical Examiner.
Date signed Sept 1st 1947

G51771

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G51771 Registered No.

1. PLACE OF DEATH: 901 S. Chapel St.
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 901 S. Chapel st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Gales

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years 60 | Months — | Days — | If less than one day hr. min.

9. Birthplace Balto. Md.
(town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER
12. Name John Gales
13. Birthplace Md.

MOTHER
14. Maiden Name Hanna ?
15. Birthplace Balto.

16 (a) Informant Mary Reed
(b) Address 1309 N. Hennitta St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 9-2-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calary Cemetery
Location Balto.

18 (a) Funeral director Walter B. Somers
(b) Address 1394 N. Hannlage Blvd.

SEP 2 1947 (Date received by registrar) Huntington Woods Station Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept Aug 29 1947, at 4½ p.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10 1947 to Aug 29 1947.
and that I last saw him alive on Aug 20 1947

Immediate cause of death: Bronchopneumonia — Duration 19 days
Due to Unknown
Due to
Other Conditions Malnutrition — Duration Unknown
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: (none)
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John V. Gaines M. D.
Address 507 N. Hamburg St. Date signed 9/2/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

G51772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G51772 ✓ 51 B Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied: correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2m 28d
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. City. 4
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1905 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Edward Boone

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	213-05-9965.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Widowed

6 (b) Name of husband or wife: deceased Rose Boone 6 (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) June 25 1872

8. AGE: Years	Months	Days	If less than one day
75	2	28	hr. min.

9. Birthplace: Frederick Co. Md. (Town, county, and state)
10. Usual Occupation: Retired Streetcar operator
11. Industry or business

FATHER
12. Name: Jacob Boone
13. Birthplace: Frederick Co. Md.

MOTHER
14. Maiden Name: Lydia Barber
15. Birthplace: Frederick County

16 (a) Informant: Hospital Records.
(b) Address: Mercy Hospital.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Sept. 2-47. (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location

18 (a) Funeral director: Charles J. Schwab
(b) Address: 3512 Frederick Ave.

SEP 2 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 30 1947 at 2p M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1947 to Aug 30 1947, and that I last saw h. alive on Aug 29 1947.

Immediate cause of death	Duration
Coronary Occlusion	Instant.
Due to: Cor. Arteriosclerosis ?	
Due to	
Other Conditions: Carcinoma, prostate Silicosis	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation: None
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:
23. Signature: John Buchner M.D.
Address: Mercy Hosp Date signed 8/30/47

94a

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G51773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G51773

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton + Wilkens ave.
(c) Hospital or institution: St. Agnes Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 11

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 6 E. Read St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jane A. Tully.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F. | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Patrick Tully +
13. Birthplace Ireland -

MOTHER 14. Maiden Name Mary Parker
15. Birthplace Ireland

16 (a) Informant Joseph P. Tully
(b) Address 257 Valentino Lane Yonkers New York

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/3/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md

18 (a) Funeral director H. H. Mears and Son
(b) Address 805 N. Calvert St

19 (a) SEP 2 1947 (Date rec'd by registrar) (Huntington Williams, M.D.)

VS-150 ...16

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1, 1947, at 4 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-25-47 19... to 9-1-47 19... and that I last saw her alive on 9-1-47 19...

Immediate cause of death Respiratory Failure — Duration

Due to General Cachexia.

Due to Malignant neoplasm, (primary source unknown)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: None obtained.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Wm. A. Langley, M.D.
Address St. Agnes Hospital Date signed 9-1-47

X

G54773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G54774 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3209 Piedmont Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3209 Piedmont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Elisabeth Smith

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29, 1873

8. AGE: Years 73 | Months 11 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Ferdinand C. Smith
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Anna C. Haberkorn
15 Birthplace Germany

16 (a) Informant Miss Carrie E. Smith
(b) Address 3209 Piedmont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/2/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc
(b) Address North & Pa. Ave, Balto. Md.

1947 SEP 2 (Date rec'd by registrar) (b) [signature]

V S 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH August 30, 1947, at 1:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from August 29 1947 to August 30 1947, and that I last saw h. alive on Aug 30 1947

Immediate cause of death: Pulmonary tuberculosis — Duration: 6 Mo.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Arthur J Davis M. D.
Address 800 N Eutaw St Date signed 9-1-47

X

G54775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 170 c

Registered No. G54775

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) One
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Cockeysville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Joyce Howard

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 1, 1910

8. AGE: Years	Months	Days	If less than one day
37	5	—	hr. min.

9. Birthplace Cockeysville Balto Co. Md (Town, county, and state)
10. Usual Occupation Telephone Operator
11. Industry or business

FATHER
12. Name S. Price Howard
13. Birthplace Balto Co, Md.

MOTHER
14. Maiden Name Edith Moreton
15. Birthplace Cockeysville Md

16 (a) Informant Mrs. Edith Howard
(b) Address Cockeysville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-4-47 (month) (day) (year)
(c) Cemetery or crematory Ebenezer Methodist
Location Sparks, Md

18 (a) Funeral director Gaylord M. Brooks
(b) Address Sparks, Md.

19 (a) SEP 2 1947 (Date received by registrar) (b) Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1, 1947, at 8:10 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Subarachnoid hemorrhage; Dislocation of cervical vertebrae; Fractures of left maxilla, sternum and left pubis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-1-47 at 7:40 P M. Estimated.
(b) Where did injury occur? Maryland & Jennifer Rds.
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? no
(d) Means of injury Auto & Auto Collision

23. Signature Earl K. Long M.D.
Medical Examiner.
Date signed 9-2-47

G5177b

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G54776

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 204 N Ellwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 204 N. Ellwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** August C. Breitenbach Sr

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Lena Breitenbach
6 (c) If alive, give age 56 years
7. Birth date of deceased (mo., day, yr.) April 11 - 1886
8. AGE: Years 61 | Months 4 | Days 20 | If less than one day ____ hr. ____ min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Police Officer
11. Industry or business Retired

FATHER
12. Name Frank Breitenbach
13. Birthplace Germany

MOTHER
14. Maiden Name Dont Know
15. Birthplace Germany

16 (a) Informant Mrs Lena Breitenbach
(b) Address 204 N Ellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 3rd (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St.

SEP 2 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31st 1947, at 12 20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 3, 1940 to Aug. 31, 1947, and that I last saw him alive on Aug. 31, 1947

Immediate cause of death	Duration
Coronary Thrombosis	1½ hrs.
Due to Arteriosclerosis	Unknown
Myocardial Damage	8 years?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip Arthur Artigiani
Address 2942 E. Fayette St. Date signed 9/2/47

X

G51777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G51777
Registered No.

A5-735-5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5708 Edgar Terrace 5108
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Sherk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-30-47

8. AGE: Years — | Months — | Days — | If less than one day: 3 hr. — min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Sherk
13. Birthplace Wash

MOTHER
14. Maiden Name Helene Seyfler
15. Birthplace Wash.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (b) Date thereof Sept. 2. 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Towson

18 (a) Funeral director William Lovell Inc
(b) Address 1217 St Paul Street

19 SEP 2 1947 (Date rec'd by registrar) Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-31-47, at 1100 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-30-1947 to 8-31-1947, and that I last saw her alive on 8-31-1947

Immediate cause of death — Duration

Prematurity

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. M. Edmonds M. D.

Address J H H Date signed 9-2-47

X

G54778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G54778

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — D.O.A.
(b) Street address
(c) Hospital or institution: 700 Fleet St. 25
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 919 DeSoto Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George A. Distler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Lota Edna Meier

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8, 1869

8. AGE: Years	Months	Days	If less than one day
77 yrs.	1	23	hr. min.

9. Birthplace Germany (Town, County, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John Distler
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Annie M. Russell
(b) Address 919 De Soto Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 3 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3501 Frederick Rd

18 (a) Funeral director Harry H. Wyke
(b) Address 4101 Edmondson Ave

19 SEP 2 1947 (Date rec'd by registrar) [illegible] Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/31 1947 at 11:59 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic CV disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. Medical Examiner.
Date signed 9/2/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C5 1779

JL 105037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. C5 1779

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(5) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2407 Christian St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Larkins or Thomas Larkin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Late Bora Finn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May ? 1874

8. AGE: Years	Months	Days	If less than one day
73	3		hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name James
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Parsons
15. Birthplace Ireland

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Sept 3 '47 (month) (day) (year)
(c) Cemetery or crematory Mount Cathedral
Location Old Frederick Rd

18 (a) Funeral director Henry A Wetzel
(b) Address 4101 Edmondson Ave

Sept 2 1947 (Date received by registrar) (b) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 31 1947; at 5.15A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 5, 1946 to Aug. 31 1947 and that I last saw him alive on Aug. 31 1947.

	Duration
Immediate cause of death Acute ant. ~~Myocardial~~ infarction	5 min.
Due to Coronary Thrombosis.	5 min.
Due to Arteriosclerosis generalized & Hyper	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 10-23-46

Major findings of operation: Concentric L ventricular hypertrophy.

of autopsy: myocardial infarction.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. E. Geoghegan M. D.
Address 4940 Eastern Ave Date signed 9-31-47

G54780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G54780

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3201 Westerwald Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3201 Westerwald Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ida L. Gillingham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wm. H. Gillingham

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 6, 1875

8. AGE: Years 72 | Months 7 | Days 25 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business

FATHER 12. Name Samuel Miles

13. Birthplace Md.

MOTHER 14. Maiden Name Elizabeth McElroy

15. Birthplace Md.

16 (a) Informant Wm. H. Gillingham

(b) Address 3201 Westerwald ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 3/47 (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location North ave. + Gay St.

18 (a) Funeral director Harry H. Luttrell

(b) Address 4016 Edmondson Ave

AUG 2 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/31/47, 19, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 3, 1947 to Aug 31 1947 and that I last saw h er alive on Aug. 31, 1947

Immediate cause of death	Duration
Melanic	
Due to Carcinoma L. Leg, Shoulder Back,	
Due to Metastasis Liver and Spleem	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]

Address 3957 W. Mrn. Date signed 9/11/47

G54781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47D

Registered No. G54781

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 625 S. Kenwood Ave
(c) Hospital or institution:
1r
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
2 (d) Street No. 625 S Kenwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Sielicki

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07 4294

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Frances

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 28 1880

8. AGE: Years 66 | Months 11 | Days 2 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Hypolit
13. Birthplace Poland

MOTHER
14. Maiden Name Zimoltas
15. Birthplace Poland

16 (a) Informant Adam Sielicki
(b) Address 625 S Kenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 3/47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore

18 (a) Funeral director Fred W Ozarowski
(b) Address 930 Eastern Ave

SEP 2 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30 1947, at 10-20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 29 1947 to Aug 30 1947, and that I last saw h alive on Aug 30 1947.

Immediate cause of death	Duration
Hemoptysis	2 days
Due to Carcinoma of lung	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene Feller M.D.

Address 2739 Edgerton Ave Date signed 9/2/47

G51782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G51782

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 700 Fleet St.
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 ?
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 121 N. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alexander Scott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years 58 | Months 6 | Days | If less than one day hr. min.

9. Birthplace Richmond Va (Town, county, and state)

10. Usual Occupation (Preacher)

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace " "

MOTHER
14. Maiden Name Unknown
15. Birthplace " "

16 (a) Informant Mary Scott
(b) Address 121 N Bond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-2-47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Woodlawn Cir 2

18 (a) Funeral director Bishop O Wilson
(b) Address

SEP 2 1947 (Date rec'd by registrar) (b) Harry Pennington for Attorney Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1947, at 2:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mackenzie M.D. Medical Examiner.
Date signed 8-29-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Typewrite or write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

G51783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. G51783

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2124 DRUID HILL AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2124 DRUID HILL AVE (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) **FULL NAME** CELESTE ROBERTS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex FEMALE

5. Color or race COLORED

6 (a) Single, married, widowed, or divorced. WIDOWED

6 (b) Name of husband or ~~wife~~ ERNEST ROBERTS

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 27, 1895

8. AGE: Years 52 Months 5 Days 2 If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Alexander Powell
13. Birthplace Balto Md

MOTHER
14. Maiden Name Martha Jane Ruggold
15. Birthplace Balto Md

16 (a) Informant Roger Roberts
(b) Address 952 N. Bond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 3, 1947 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill from Chr
Location Baltimore Co. Md.

18 (a) Funeral director Wm Geo H. Holland
(b). Address 1631 Edmondson Ave

19 (a) SEP 2 1947 (Date rec'd by registrar) (b) Huntington Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 29 1947 at 9:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 22, 1947 to Aug. 29 1947 and that I last saw h[illegible] alive on Aug. 28 1947

Immediate cause of death	Duration
CARCINOMATOSIS	UNDET.
Due to CARCINOMA of RECTUM	UNDET.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas W. Hans M. D.
Address 1824 Franklin St. Date signed 8-29-47

G54784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

G54784 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Providence Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. Jessups Md (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Thomas

3 (b) If veteran, name war: W.W. 2
3 (c) Social Security Account No. —

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/10/1927

8. AGE: Years 19 | Months 10 | Days 20 | If less than one day ..... hr. ..... min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Wm J. Thomas
13. Birthplace Va

MOTHER 14. Maiden Name Blanche Lewis
15. Birthplace Va

16 (a) Informant Wm J. Thomas
(b) Address Jessups, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/47 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Pennsylvania Ave

19 SEP 2 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1947, at 3:00 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Bullet-wound of brain
Due to: Bullet-wound of neck and right chest.
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-30-47 at 2:45 P M.
(b) Where did injury occur? Harlem Ave + Stricker
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? no
(d) Means of injury Firearms

23. Signature George H. Merrill M.D. Medical Examiner.
Date signed 8/30/47

VS 151

G54785

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

Registered No. G51785

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 913 Iris St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 913 Iris St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie M. Pentz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Thomas C. Pentz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11-1859

8. AGE: Years	Months	Days	If less than one day
87	11	20	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name John J. Gorsuch
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Sally Griffin
15. Birthplace Balto. Md.

16 (a) Informant Mrs. George Koenner
(b) Address 913 Iris St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 3-47 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location North Ave. & Gay St.

18 (a) Funeral director John L. Miller
(b) Address 2334 Jefferson St.

19 SEP 2 1947 (Date rec'd by registrar) (b)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31 1947, at 5A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1944 to Aug 31 1947 and that I last saw her alive on Aug 30 1947.

Immediate cause of death	Duration
Squamous Cell Carcinoma (face & chest wall)	5 yrs
Due to	
Due to	
Other Conditions Chronic Myocarditis Degeneration	5 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David Schneider M. D.
Address 110 N. Wilson Ave Date signed 9-1-47

G54786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G54786

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2239 McElderry St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2239 McElderry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles E. Clemens

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-07-4849

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Rebecca Clemens

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28-1874

8. AGE: Years 72 | Months 9 | Days 3 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER 12. Name James D. Clemens

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Mary Ella Hanson

15. Birthplace Balto. Md.

16 (a) Informant Mrs. Bessie Smith

(b) Address 2239 McElderry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 3/47 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cem.

Location North Ave + Gay St.

18 (a) Funeral director John G. Miller

(b) Address 2334 Jefferson St.

SEP 2 1947 (Date rec'd by Registrar) Washington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 31 1947 at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 4 1946 to Aug 31 1947 and that I last saw deceased alive on Aug. 31 1947.

Immediate cause of death: Acute Cardiac Failure — Duration 8 hours

Due to: Hypertensive Cardiovascular Renal Disease — 6 years.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Israel Rosen

Address 2413 E. Monument St. Date signed 9/4/47 (M. D.)

X

G51787

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G51787

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 818 - N. Winston
(If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country —

3 (a) FULL NAME Amanda (wife of) Eads Eads

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Widowed

6 (b) Name of husband or wife — (deceased)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-3-07

8. AGE: Years	Months	Days	If less than one day
40	2	27	— hr. — min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name William Wilson
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Sarah Chase
15. Birthplace Chase, Maryland

16 (a) Informant Ruth A. Curry
(b) Address 1277 Atlantic Ave. Brooklyn 16, N.Y.

17 (a) Burial (b) Date thereof 9-3-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director Joseph L. Russ
(b) Address 1206 Druid Hill Ave.

19 SEP 2 1947 (b) [illegible]
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1947, at 3:27 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-29 1947 to 8-30 1947, and that I last saw h[illegible] alive on 8-30 1947 @ 12:25 Pm

Immediate cause of death

	Duration
Coronary Occlusion	
Due to Hypertensive C-V Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature J. Preston Hart M.D.
Address 1504 Division St Date signed 8/31/47

X

G54788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G54788
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 42 N. Caroline St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME David Backey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Lula

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1877

8. AGE: Years	Months	Days	If less than one day
70	1	13	hr. min.

9. Birthplace Lemasville, Jefferson Co., Ga. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Backey
13. Birthplace Lemasville, Jefferson Co, Ga

MOTHER
14. Maiden Name Rosa Gladman
15. Birthplace Lemasville, Jefferson Co. Ga.

16 (a) Informant Jackson Scott
(b) Address 914 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 2, 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St

19 Sep 2 1947 (Date rec'd by Registrar) Huntington Williams M[illegible] (Registrar) signed

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28, 1947, at 11 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions Fracture of femur

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☒ cause of death, fill in the following:
(a) Date of injury July 29 1947 7 P.M.
(b) Where did injury occur? In front of 42 N. Caroline St
(c) Did injury occur at home, on farm, industrial place, in public place? Street While at work? No
(d) Means of injury Fell while coasting.

23. Signature George L. Merrill M.D. Medical Examiner.

signed 8-28-47

G54789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓61

G54789 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 515 E. 21st St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Elizabeth Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1899

8. AGE: Years	Months	Days	If less than one day
48	1	21	7 hr. 30 min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Social Security Worker

11. Industry or business

FATHER
12. Name Basil Smith
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elizabeth McConnel
15. Birthplace Balto. Md.

16 (a) Informant Margaret Fraze
(b) Address Manassas, Virginia

17 (a) Burial (b) Date thereof 9-3-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location City

18 (a) Funeral director Wiedefeld & Son.
(b) Address Greenmount Ave & 22nd St.

19 (a) SEP 2 1947 (Date rec'd by Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 31, 1947 at 7:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 31, 1947 to Aug. 31, 1947 and that I last saw him alive on Aug. 31, 1947

Immediate cause of death	Duration
Cerebral Hemorrhage	5 hrs.
Due to Hypertensive CV-R disease	5 and 1/2 yrs.
Due to Chronic Glom. Nephritis	" "
Other Conditions Diabetes Mellitus; Passive Congestion, Coronary insufficiency	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: Coronary Insufficiency, Cerebral Hemorrhage, Hypertensive Cardiovascular Renal Disease

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph LiPuma M. D.
Address Mercy Hosp Date signed 9-31-47

131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54790

433605-4

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G54790 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Hanover, (If outside city or town limits, write RURAL and give town)
(d) Street No. 207 Baltimore, St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank H. Weems.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Madeline Weems
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 11-26-97

8. AGE: Years	Months	Days	If less than one day
49	9	5	hr. min.

9. Birthplace Ill. (Town, county and state)
10. Usual Occupation Laundry Supplies
11. Industry or business

FATHER
12. Name Frank H. Weems
13. Birthplace Iowa.

MOTHER
14. Maiden Name Ann Lee.
15. Birthplace Ill.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 4 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Hanover Pa

18 (a) Funeral director Jacob Wintz & Son
(b) Address Manchester

19 SEP 2 1947 (b) Huntington Williams M.D.
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept - 1 - 1947 at 11 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-26- 1947 to 9-1- 1947 and that I last saw him alive on 9-1- 1947.

Immediate cause of death	Duration
Pulmonary Tuberculosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature M.D.
Address Date signed

G54791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

49D

Registered No. G54791

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. REMOVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 306 South Clinton Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 306 South Clinton Street (If rural, give location) 10
(e) Citizen of foreign country? (Yes or No) X
If yes, name country

3 (a) FULL NAME Mary Britcher

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: William H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13 1862

8. AGE: Years 85 | Months 4 | Days 18 | If less than one day ____ hr. ____ min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Bishop
13. Birthplace England

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Germany

16 (a) Informant Richard William Hogan
(b) Address 339 South Clinton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 3 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Wilkens Avenue

18 (a) Funeral director Tully & Zucker Inc.
(b) Address 403 South Wolfe Street

19 (a) SEP 2 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/31/47, 19, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/10/47 19 to 8/31/47 19, and that I last saw him alive on 8/24/47 19

Immediate cause of death: Cardio Respiratory failure — Duration
Due to: Coronary Thrombosis.
Due to:
Other Conditions: Carcinoma Uterus.
(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John M. Falcon
Address 116 S. Chase St Date signed 9/2/47 (M) (D)

94a

G51792

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V94a

Registered No. G54792

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2202 Mt Royal Terrace
(c) Hospital or institution: 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) about 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2202 Mt Royal Terrace (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Antonio Luis Nicolau

3 (b) If veteran, name war
3 (c) Social Security Account No. 212-10-3353 [redacted]

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	widowed

6 (b) Name of husband or wife Dorothy King
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1891

8. AGE: Years	Months	Days	If less than one day
56	7	23	hr. min.

9. Birthplace Spain (Town, county, and state)
10. Usual Occupation Interpreter - Spanish
11. Industry or business Md. Casualty Co.

FATHER
12. Name (unknown)? Nicolau
13. Birthplace Spain

MOTHER
14. Maiden Name Charity Grada
15. Birthplace Spain

16 (a) Informant Miss Dorothy Nicolau
(b) Address 2202 Mt. Royal Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/2/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto., Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) SEP 2 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/30 19 47 at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ causes of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. F. Sulbrinke M.D. Medical Examiner.
Date signed 8/31/47

G54793

AB- 111827

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1382

G54793 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 17-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 6yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 506 West Preston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Naomi Burns

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col.	Separated

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7- 1924

8. AGE: Years	Months	Days	If less than one day
23	2	22	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Hobert Johnson
13. Birthplace Virginia

MOTHER
14. Maiden Name Lucille Moulton
15. Birthplace Virginia

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 2, 47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location Brooklyn, Md.
18 (a) Funeral director Elton W Wilson
(b) Address 1000 Bentley ave
1947 SEP 2 (b) (Date rec'd by registrar) Lexington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1947, at 8 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-1 1947, to 8-29 1947, and that I last saw h. alive on 8-29 1947.

	Duration
Immediate cause of death: Respiratory failure	3 da.
Due to: Tuberculosis of lungs	14 yr.
Due to: fibroadenoma	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Joseph J Bowen Jr. M.D.
Address Balt. City Hosp. Date signed 8-30-47

G54794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G54794

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address DOA
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 109 N. Carey St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eugene J. Miller

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Otta Rita
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1881

8. AGE: Years: 66 Months: 3 Days: 21 If less than one day hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual Occupation: Laborer
11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden Name: "
15. Birthplace: "

16 (a) Informant: Paul J. Conroy
(b) Address: 901 Hollins St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/3/47 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn
Location: 4300 Old Frederick Road

18 (a) Funeral director: Hugh Bowers & Son
(b) Address: 901 Hollins St

19 (a) SEP 2 1947 (Corrected by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/31 1947 at 9:00 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: P. J. Sabatiello M.D.
Medical Examiner.
Date signed 9/3/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54795

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G54795

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy 27-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3334 Woodland Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Terwilliger (MARY FRANCES TERWILLIGER)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Erwin B. Terwilliger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9, 1884

8. AGE: Years	Months	Days	If less than one day
62	8	21 2	3 hr. min.

9. Birthplace Ireland.
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name David Healy
13. Birthplace Ireland.

MOTHER
14. Maiden Name Catherine Monaghan
15. Birthplace Ireland.

16 (a) Informant Erwin B. Terwilliger
(b) Address 3334 Woodland Ave.

17 (a) Burial (b) Date thereof 9/4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. City

18 (a) Funeral director C. Vernon Hennegan
(b) Address 4417 Park Heights

19 (a) SEP 2 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1 1947 at 7:15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 17 1947 to Sept 1 1947 and that I last saw her alive on Sept 1 1947

Immediate cause of death	Duration
Carcinoma of the stomach with	
Due to retroperitoneal metastasis	
Due to	
Other Conditions Pentonitis	

(Include pregnancy within 3 months of death)
Date of operation Aug 26, 1947
Major findings of operation Carcinoma of stomach
of autopsy Metastasis Peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature W. A. Schmitz M. D.
Address Mercy Date signed 9-1-47

VS 150

G54796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55B

Registered No. G54796

PRESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 61 days
(e) Length of stay in Baltimore (yrs., mos., or days) 75 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore 18
(If outside city or town limits, write RURAL and give town)
(d) Street No. 19 East 21st St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Elizabeth M. Lehr

3 (b) If veteran, name war

3 (c) Social Security Account No. Unknown

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) October 9, 1871

8. AGE: Years	Months	Days	If less than one day
75	10	22	— hr. — min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation School Teacher (Retired)
11. Industry or business Balto. City Schools.

FATHER
12. Name William F. Lehr
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Moller
15. Birthplace Germany

16 (a) Informant Mrs. Mary Jackson
(b) Address 5718 Ritchie Highway. Balto 25, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 3, 1947 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Cedar Hill (Brooklyn R.F.D.)

18 (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie, Maryland

19 (a) (Date rec'd by registrar) (b) Huntington Holding (1)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1 1947, at 1:30 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 19 , to 19 , and that I last saw her alive on August 31 1947.

Immediate cause of death	Duration
Respiratory Failure	
Due to Generalized Carcinomatosis	3 mos.
Due to Lymphosarcoma of Spine	6 mos.-1 yr.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation July 2, 1947
Major findings of operation: Extradural cord tumor
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel A Bell M.D.
Address Union Memorial Hospital Date signed Sept 1.

G54797

TN. 103145

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1947

G54797 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 1- & 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 709 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward G. Warns

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Jennie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 16th. 1877

8. AGE: Years	Months	Days	If less than one day
70	5	15	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Guard
11. Industry or business

FATHER
12. Name Frank
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabath Davis
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (b) Date thereof 9/4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Parkville Balto Co.

18 (a) Funeral director Wm Cookman
(b) Address 217 S9 Paul St

19 SEP 3 1947 Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1st/1947 19 , at 2.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 23 1946 , to Sept 1/ 1947 , and that I last saw h im alive on Sept 1st 1947 .

Immediate cause of death	Duration
Bronchopneumonia	weeks
Due to	
Due to	
Other Conditions Hypertension Heart Decom - Cerebral Hemorrhage	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J E Robinson Jr M. D.
Address Balt. City Hosp Date signed 9/4/47

107

G54798 ST

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G54798 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. NOTICE—THIS CERTIFICATE MUST BE FILLED OUT AND SIGNED BEFORE IT IS PRESENTED FOR BURIAL

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4614 Elsrode Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4614 Elsrode Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth T. Spellman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Howard C. Spellman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 6-1897

8. AGE: Years	Months	Days	If less than one day
50	4	25	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Kabosta
13. Birthplace Germany

MOTHER
14. Maiden Name Julia Bealky
15. Birthplace Germany

16 (a) Informant Howard C. Spellman
(b) Address 4614 Elsrode Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 3-1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore - Maryland

18 (a) Funeral director William Cook Inc.
(b) Address 1211 St. Paul st. Balto. Md.

19 (a) Date rec'd by registrar SEP 3 1947 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 31 1947 at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-27 1947 to 8-31 1947 and that I last saw h[illegible] alive on 8-31 1947.

Immediate cause of death Coronary Thrombosis — Duration 5 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. W. Peake M. D.
Address 112 S. St. Paul Date signed 9-2-47

G51799 [illegible]ington St. BALTIMORE CITY HEALTH DEPARTMENT G51799
Registered No.

CERTIFICATE OF DEATH 83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 941 Abbott Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 941 Abbott Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Hanlon

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elizabeth R. Hanlon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan-24-1877

8. AGE: Years	Months	Days	If less than one day
70	7	3 7	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Night Watchman
11. Industry or business

FATHER
12. Name Thomas Hanlon
13. Birthplace Unknown

MOTHER
14. Maiden Name Katherine Gunnip
15. Birthplace Unknown

16 (a) Informant Elizabeth R. Hanlon
(b) Address 941 Abbott ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 4-1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul ST. Balto

SEP 2 1947 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/31 1947 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 6 1947 to Aug 31 1947 and that I last saw h[illegible] alive on Aug 31 1947.

Immediate cause of death Cerebral accident — Duration
Due to Hypertension
Due to Arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Conrad L. Pantry
Address 1706 N. Wash. St Date signed 9/2/47

X

C54800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 148a

C54800 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Rutland St
(c) Hospital or institution West Baltimore Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 45 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1508 W. Royal Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. MARY C. BYRNE Mary G. Byrne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	M.

6 (b) Name of husband or wife Thomas L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC 3, 1909

8. AGE: Years	Months	Days	If less than one day
37	8	29	hr. min.

9. Birthplace Tennessee
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Thos. L. Gilliland
13. Birthplace unk

MOTHER 14. Maiden Name Mary Cosom
15. Birthplace Tenn.

16 (a) Informant Family
(b) Address 1508 W. Royal Ave.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 9-6-47 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet
Location Baltimore Md.

18 (a) Funeral director L. McCauley.
(b) Address No. 3. East Ave

SEP 8 1947 (Date received by registrar) Huntington Williams (Registrar)

VS 150 [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 SEPT 1947, at 9:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7 July 1947 to 1 SEPT 1947, and that I last saw her alive on 1 SEPT 1947.

	Duration
Immediate cause of death Uremia	1 mo
Due to Pelvic Carcinomatosis	9 mo
Due to Cancer of Cervix	9 mo
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation July 22 '47
Major findings of operation: Cancer of Cervix
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Calvert Hardy
Address West Balt Gen'l Hosp Date signed 9/1/47 M. D.

G54801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

Registered No. G54801

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 622 E. Heath St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 622 E Heath St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME August G. Bloom

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Juanita Heil

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/15/1903

8. AGE: Years 44 | Months 3 | Days 16 | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Cab Driver

11. Industry or business G. I. Co.

FATHER 12. Name Maurice

13. Birthplace Poland ?

MOTHER 14. Maiden Name Lena

15. Birthplace Poland

16 (a) Informant Family

(b) Address 622 E. Heath St

17 (a) D. (Burial, cremation, or removal) (b) Date thereof 9-3-47 (month) (day) (year)

(c) Cemetery or crematory Loudon Pk

Location Harlaugh Ave.

18 (a) Funeral director L. Lee Conely

(b) Address 136 E. Fort Ave

19 SEP 3 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/31 1947, at 5 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary arteriosclerosis

Myocardial degeneration

Due to Edema of lungs

Edema of brain

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.

Date signed 9/4/47

G54802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G54802 Registered No. 1406

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 261 So. Dallas (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cleo Monahan Monaghan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph Monahan

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 7-31-19

8. AGE: Years 28 | Months — | Days 1 | If less than one day — hr. — min.

9. Birthplace Penna. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Angus Woomer

13. Birthplace Penna.

MOTHER 14. Maiden Name Emma Miller

15. Birthplace Penna.

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 4 47 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location 4300 Old Frederick, Rd,

18 (a) Funeral director Lilly and Zeiler, Inc

(b) Address 403 S. Wolfe, St.

SEP 2 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-1-1947, at 5:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-31-1947, to 9-1-1947, and that I last saw her alive on 9-1-1947.

Immediate cause of death	Duration
Pulmonary edema	
Due to Overwhelming Septicemia	
Due to Puerperal Sepsis	
Other Conditions Thrombocytopenia, Spontaneous Miscarriage	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As Above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sherman M. Mellinkoff

Address Johns Hopkins Hosp. Date signed 9/2/47

G54803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G54803 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4235 Ivanhoe Avenue
(c) Hospital or institution: 7

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4235 Ivanhoe Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES ALEXANDER JONES

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 476- 20- 5374

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widower

6 (b) Name of husband or wife: Mabel A. Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 27, 1870

8. AGE: Years	Months	Days	If less than one day
76	11	7 6	hr. min.

9. Birthplace Canada
(Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name James Jones
13. Birthplace Canada

MOTHER
14. Maiden Name Unknown
15. Birthplace Canada

16 (a) Informant Mr & Mrs. John C. Donohue
(b) Address 4235 Ivanhoe Avenue

17 (a) Burial (b) Date thereof 9--3-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Westover Memorial
Location Augusta, Ga.

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE & BROADWAY

SEP 3 1947 (a) (b)
(Date rec'd by registrar) Registrar

V. S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 - 3 1947, at 3 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7 - 15 1947 to 9 - 3 1947 and that I last saw him alive on 9 - 3 1947

Immediate cause of death: Myocarditis — Duration:
Due to: Arteriosclerosis - senility
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Swartz Jr. M. D.
Address 36 York Ct. Date signed 9-3-47

G54804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8-3a

G54807

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1731 N. Patterson Park Ave
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1731 N. Patterson Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John S. Dunlap

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Alvinda Dunlap
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 25th 1866

8. AGE: Years: 81 | Months: - | Days: 7 | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Retired Gracerman

11. Industry or business

FATHER
12. Name Hugh Dunlap
13. Birthplace Penna.

MOTHER
14. Maiden Name Margaret Peoples
15. Birthplace Penna

16 (a) Informant Mrs. Dunlap
(b) Address 1731 N. Patterson Park Ave

17 (a) Burial (b) Date thereof Sept 5 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Wesley M. E. Church
Location Jacksonville Md

18 (a) Funeral director Leo G. Crook
(b) Address 1701-03 N. Patterson Park Ave

19 (a) Date received SEP 2 1947 (b) Huntington Williams M.D.
(Local registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2nd 1947 at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1946 to Sept 1947.
and that I last saw him alive on Sept 1 1947.

Immediate cause of death: Coronal accident

Due to Hypostasis

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Conrad L. Richters

Address 1706 N. Ward St Date signed 9/2/47

VS 150

G54805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

G54805 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 90 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2062 Druid Park Drive
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME George Walter Billingsley

3 (b) If veteran, name war: WW I
3 (c) Social Security Account No. 218-07-1877

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Ollie Taggart Billingsley
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1888

8. AGE: Years 58 | Months 9 | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Samuel Billingsley
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Shriner
15. Birthplace Carroll Co. Md.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 5-1947 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) SEP 3 1947 (Date rec'd by registrar) (b) Huntington-Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2 1947, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 4 1947, to Sept. 2 1947, and that I last saw him alive on Sept. 2 1947.

Immediate cause of death Carcinoma, bronchogenic, right lung with widespread metastasis — Duration: UNKNOWN

Due to

Due to

Other Conditions Pneumonia, bronchial, left lung — Duration: SEVERAL DAYS

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M.D.
Address Clinical Director Date signed 9/2/47

X

G54806

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 50

Registered No. G54806

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly. DO NOT FOLD OR BEND

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St. & Linden Ave
(c) Hospital or institution: Maryland General Hospital | 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 175 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(c) Street No. 3413 Gwynns Falls Pkwy & 16
(If rural give location)
(d) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jeanette H. Shenton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Harry W. Shenton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 18 Dec 1897

8. AGE: Years: 49 | Months: 8 | Days: 13 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: housewife

11. Industry or business

FATHER
12. Name: Frank O. Heydenrich
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: Clara Woodall
15. Birthplace: Baltimore

16 (a) Informant: Mr. Harry H. Shenton
(b) Address: 3413 Gwynns Falls Pkwy.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/3/47 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

SEP 3 1947 (Date rec'd by registrar) (b) Livingston Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 Sept 1947 at 5:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 17 Apr 1947 to 1 Sept 1947, and that I last saw h[illegible] alive on 1 Sept 1947.

Immediate cause of death	Duration
Generalized carcinomatosis	3 yrs
Due to	
Due to	over
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G. Allan Dyer M. D.
Address Md. Gen. Hosp. Date signed 1 Sept 47

VS 150

G54807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1240

G54807 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 101 East 33d St.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 221 Dunbridge Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Fred H. Gettemuller

3 (b) If veteran, name war

3 (c) Social Security Account No. 284-03-7977

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Minnie J. Gettemuller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21, 1878

8. AGE: Years	Months	Days	If less than one day
69	4	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Executive
11. Industry or business

FATHER
12. Name Henry J. Gettemuller
13. Birthplace Germany

MOTHER
14. Maiden Name Amelia Merde
15. Birthplace New York

16 (a) Informant Mr. George Gettemuller
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 3 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1 1947, at 6:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-26 1947 to 9-1 1947, and that I last saw him alive on 9-1 1947.

Immediate cause of death	Duration
Cardiac & Resp. failure	
Due to Severe Cirrhosis of liver	
Due to Severe Polycythemia	
Other Conditions Coma	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury Budd

23. Signature Samuel O Budd
Address Union Memorial Hospital Date signed Sept 1 1947 M.D.

X

G54808

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 199

Registered No. G54808

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4211 Elderon Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4211 Elderon Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LAURA VIRGINIA MORGAN

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
no	no	female	white	widow

6 (b) Name of husband or wife Charles Edward Morgan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1855

8. AGE: Years	Months	Days	If less than one day
91	11	11	hr. min.

9. Birthplace Washington, D. C. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Peter D. Della
13. Birthplace Md.

MOTHER
14. Maiden Name Emily A. Ross
15. Birthplace Md.

16 (a) Informant Mrs. Cora E. Sweet
(b) Address 4211 Elderon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/3/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Mausoleum
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 3 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 31, 1947, at 5:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/30 1947 to 9/31 1947.
and that I last saw her alive on 9/30 1947.

Immediate cause of death	Duration
Myocardial failure	2 yrs
Coronary arterial occlusion	5 days
Due to Acute Generalized Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Thomas L. Wardley Jr.
Address 2900 Alameda Md. Date signed 9/1/47

X

G54809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G54809

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, 9-7 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1629 Carswell Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence A. POEHLER

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margaret May Poehler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 21, 1886

8. AGE: Years	Months	Days	If less than one day
61	7	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name John Bernard Poehler
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Frances Fortman
15. Birthplace Balto., Md.

16 (a) Informant MRS. Margaret May Poehler
(b) Address 1629 Carswell St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/3/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 4 1947 (Date rec'd by reg.) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1, 1947 at 7 A. M.

21. I certify that I took charge of the remains described above, held an Inspection and Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

~~Due to~~ History of chronic alcoholism

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D. Medical Examiner.
Date signed 9/4/47

G54810
396 97

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 48a

G54810
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1455 Pennsylvania Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Washington.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 13, 1909

8. AGE: Years 40 | Months - | Days 19 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name John Johnson -
13. Birthplace Md -

MOTHER
14. Maiden Name Catherine Chew
15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/5/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Wm. B. Nelson
(b) Address 1303 Pressman St

19 (a) S.F.D. 2 (b) Date rec'd by local registrar 1947 Washington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1 1947 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 31 1947 to Sept 1 1947 and that I last saw her alive on Sept 1 1947

Immediate cause of death: Carcinoma of Cervix Uteri — Duration: 2

Due to Uremia.

Due to Urinary Obstruction.

Other Conditions.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert P. O'Donnell M.D.

Address Johns Hopkins Hospital Date signed Sept. 2 1947

X

G54811 BCH B-71638 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 108 G54811

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. DO NOT FOLD FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 608 N. Carey St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gilbert Johnson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	N	Sngl.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/24/43

8. AGE: Years	Months	Days	If less than one day
	6	5	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER 12. Name Wilbert Holmes
13. Birthplace Md

MOTHER 14. Maiden Name Jennie Johnson
15. Birthplace Md

16 (a) Informant Wilbert Holmes
(b) Address 608 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/43 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Mrs. H. Nelson
(b) Address 1303 Presstman St

19 SEP 3 1943 (Date rec'd by Registrar) (b) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/1 1943, at 7:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 1943 to 9/1 1943, and that I last saw h.. alive on 9/1 1943.

Immediate cause of death
Lobar Pneumonia — Duration 7

Due to

Due to

Other Conditions Bilateral Cata... Otitis Media
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Paxton Hart M. D.
Address 1514 Division Date signed 9/1/43

GG54812 BC# B-87271

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

160c

GG54812 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline
(c) Hospital or institution: St. Josephs
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) Same

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2802 Miles Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Shipp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/28/47

8. AGE: Years	Months	Days	If less than one day
0	0	0	2 hr. 25 min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William H Shipp.
13. Birthplace Alliance Ohio

MOTHER
14. Maiden Name Margaret Mary Hayes
15. Birthplace Baltimore Md.

16 (a) Informant Mother.
(b) Address 2807 Miles Ave. Baltimore

17 (a) Burial (b) Date thereof Sept 5 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd. Balto

SEP 2 1947 (b) Huntington Williams
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/29 1947 at 12:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 28 Aug. 1947 to 29 Aug. 1947 and that I last saw him alive on 29 Aug 1947.

Immediate cause of death Prematurity

Duration
2-3 weeks

Due to Premature separation of placenta

Due to Placenta Praevia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Delivered by Caesarean Section

Major findings of operation 8/28/47

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James L Hartle M. D.
Address St Josephs Hospital Date signed 8/29/47

G54813

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G54813 Registered No. 95 c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave & Madison St.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Baltimore
(b) City or town ~~Forest Cantonton Plaza #11~~
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3105 Cantonton Plaza #11
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Nace

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-9940

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife John H. Nace
6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) 10 Oct 1904

8. AGE: Years	Months	Days	If less than one day
42	10	23	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name William H Gibson
13. Birthplace Va

MOTHER
14. Maiden Name Lilly Martin
15. Birthplace Md

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 5. 47 (month) (day) (year)
(c) Cemetery or crematory St Marys Hampden
Location Baltimore Md

18 (a) Funeral director Frank H Bentz
(b) Address 814 W. 36 St

19 (a) SEP 3 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 Sept, 1947, at 330 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 26 Aug 1947, to 2 Sept 1947, and that I last saw h[illegible] alive on 2 Sept 1947.

Immediate cause of death	Duration
Uremia	1 week
Due to Circulatory failure	1 week
Due to Ventricular flutter	1 week
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Allan Spiro
Address Md. Gen. Hosp. Date signed Sept 3 1947

X

G54814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G54814

Registered No. 50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 101 East 33d St.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 yrs. 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. Y. (b) County
(c) City or town New York White Plains (If outside city or town limits, write RURAL and give town)
(d) Street No. 11 Greenridge Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Eva Isabel Loche

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20, 1887

8. AGE: Years	Months	Days	If less than one day
60	4	13	hr. min.

9. Birthplace New York (Town, county, and state)
10. Usual Occupation School Teacher
11. Industry or business

FATHER
12. Name Franklin T. Loche
13. Birthplace New York

MOTHER
14. Maiden Name Minney Northrup
15. Birthplace Canada

16 (a) Informant Mrs. Eva I. Clearwater
(b) Address Hopkins Apts. Balto. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/3/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Hope
Location Ticonderoga, N.Y.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place

SEP 3 1941
(Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 2 1947, at 7:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-9 1947 to 9-2 1947 and that I last saw her alive on 9-2 1947

Immediate cause of death	Duration
Carcinoma Breast - rt. with generalized metastases	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Williams M. D.
Address Date signed

Hosp X 9-2-47

G54815 BALTIMORE CITY HEALTH DEPARTMENT G54815
CERTIFICATE OF DEATH 186a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway Fairmount
(c) Hospital or institution:
Church Home and Hospital 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 years
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. Broadway & Fairmount
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Bertha Bigelow

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race White

6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife W.O. Bigelow deceased

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 3 (1860)

8. AGE: Years (80) 87 | Months 0 | Days 29 | If less than one day ..... hr. ..... min. | 86

9. Birthplace Baltimore City Maryland
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name John A. McKelvy
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary E. Bishop
15. Birthplace Virginia

16 (a) Informant E.R. Spanner RN.
(b) Address Church Home. Hospital.

17 (a) Burial (b) Date thereof 9/5/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Anne's
Location Annapolis, Md.

18 (a) Funeral director John C. Mitchell & Son
(b) Address 1900 Eutaw & Lanvale
(c) (Date rec'd by registrar) Langston Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2 1947 at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 20 1947 to Sept 2 1947 and that I last saw her alive on Sept 2 1947.

Immediate cause of death Pneumonia + Uremia — Duration 29 days
Due to Fracture Right Femur Intertrochanteric
Due to
Other Conditions Diabetes Mellitus Senility
(Include pregnancy within 3 months of death)
Date of operation Aug 6 1947
Major findings of operation: Fracture Rt Femur
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 6/5
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence August 3 at 2:00 P M
(c) Where did injury occur? Baltimore City Md.
Broadway & Fairmount (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Sidewalk While at work? No
(Specify type of place)
(e) Means of injury Accidental Fall

23. Signature Kirk Moore M.D.
Address Church Home Hosp. Date signed 9-2-47 M. D.

Cleared By Medical Examiners office
Howard J. Mc Donnell M.D.

VS 150

G54816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 56E

G54816 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th ST
(c) Hospital or institution: Home for Incurables 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-7-22
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W. 40th St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET LEONE ABBOTT

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: White | 6 (d) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 16, 1904

8. AGE: Years 43 | Months 6 | Days 17 | If less than one day hr. min.

9. Birthplace BALTIMORE, Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name John Abbott
13. Birthplace CARROLL Co. Md

MOTHER
14. Maiden Name EMMA Bond
15. Birthplace ST. MARY's Co., Md.

16 (a) Informant S.E. Ross. Baptist Home for Incurables
(b) Address 700 W. 40th St. Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Windsor Mill Rd. Woodlawn Md.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Pl.

19 (a) 1947 (Date rec'd by registrar) (b) Registrar

VS 3

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2 1947, at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 11 1941 to 9/2 1947. and that I last saw h alive on 9-2 1947.

	Duration
Immediate cause of death: Cerebral Vascular accident	2 Days.
Due to: Arteriosclerosis (Primary)	6 years
Due to: Generalized Hemo-fibrometosis	Life
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Graeton Hershey
Address 214 Medical Arts Bldg Date signed 9/3/47

G54817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G54817 Registered No. 830

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 65 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 202 Tunbridge Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert A. Sindall ROBERT ALLISON SINDALL SR.

3 (b) If veteran, name war: None

3 (c) Social Security Account No. ?

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Maria E. Sindall
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) 6-9-1883

8. AGE: Years 65 | Months 2 | Days 24 | If less than one day ..... hr. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation manufacturer

11. Industry or business Canning Machinery

FATHER
12. Name Samuel M. Sindall
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Caroline Stewart
15. Birthplace Balto. Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 9/5/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

SEP 8 1947 (Huntington Williams M.D.)
(Date received by registrar)

MEDICAL CERTIFICATION A

20. DATE OF DEATH Sept. 3 1947 at 1. M

21. I certify that death occurred on the date above stated; that I attended deceased from July. 4 1947 to Sept. 3 1947, and that I last saw h. im alive on Sept. 3 1947.

	Duration
Immediate cause of death Probable pulmonary infarction, R L L	
? ? Multiple pulmonary infarctions	
Due to Moderate cerebral atherosclerosis, right, c left hemiplegia	
Due to Terminal ventricular fibrillation and hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Norman E. Shumway
Address Johns Hopkins Hospital Date signed 9-3-47 M. D.

VS 150

X

G54818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G54818 Registered No.

51 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Eutaw Place.
(c) Hospital or institution: Ellingson nursing Home, Balto. Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Glyndon, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 322 Central Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Gempp

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-16-5147

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widower

6 (b) Name of husband or wife Bessie S. Gempp
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1873

8. AGE: Years	Months	Days	If less than one day
74	3	20	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Oiler
11. Industry or business W. E. Hooper

FATHER
12. Name George Gempp
13. Birthplace Md.

MOTHER
14. Maiden Name Sadie Myers
15. Birthplace Germany

16 (a) Informant Mrs. M. Shaw Meredith
(b) Address 322 Central Ave., Glyndon, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/47 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) RECEIVED 1947 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2 1947, at 7:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-19 1945, to 8-27 1947, and that I last saw him alive on 8-27 1947.

Immediate cause of death	Duration
Uremia	1 wk.
Due to Ca of Prostate.	3 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None. at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. D. Caples, M. D.
Address Reisterstown, Md. Date signed 9-2-'47

M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH - 13B

G54819 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19dy
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 232 Pearl St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alma Bynum

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7, 1903

8. AGE: Years	Months	Days	If less than one day
44	5	24	hr. min.

9. Birthplace Suffolk, Virginia
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Joe Bynum
13. Birthplace Virginia

MOTHER
14. Maiden Name Julia
15. Birthplace Virginia

16 (a) Informant Mary Williams
(b) Address 772 Waelcher St.

17 (a) BURIAL (b) Date thereof 9-5-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.
Remington-Holbrook, M.D.

19 (a) (b)
(Date received by Registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31 1947 at 8:45 M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Pulmonary tuberculosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William L. Selbach M.D.
Medical Examiner.
Date signed Sept 1, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54820

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

G54820 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 673 Sarahann Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas PLOWDEN

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years 44 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name
13. Birthplace Maryland

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof 9-4-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 (a) SEP 3 1947 (b) Huntington-Williams Co.
(Date rec'd by registrar) (Signature)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31 1947 at 6 12 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet-wound of abdomen
Peritonitis
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1:35 a.m. 8/30/47
(b) Where did injury occur? 673 Sarahann St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearm

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 9/4/47

G54821

BALTIMORE CITY HEALTH DEPARTMENT

Acct # 87434 CERTIFICATE OF DEATH 159

G54821
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 210 Asquith St. 3 y 2
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Steve Rycer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 22 1947

8. AGE: Years | Months | Days 2 | If less than one day ____ hr. ____ min. (2 days)

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Robert Rycer

13. Birthplace Spindale, N.C.

MOTHER 14. Maiden Name Evelina Miller

15. Birthplace Rutherfordton N.C.

16 (a) Informant V. Nash, R.N.

(b) Address Provident Hosp.

17 (a) ____ (b) Date thereof ____
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School AUG 29 1947

18 (a) Funeral director Commissioner of Health

(b) Address

SEP 3 1947 Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 24 1947, at 1:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 22 1947 to Aug. 24 1947 and that I last saw him alive on Aug. 24 1947

Immediate cause of death	Duration
ASPHYXIA NEONATORUM	
Due to PREMATURITY	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eldean Vreede M.D.

Address Provident Hosp. Date signed 8/24/47

G54822 HEALTH DEPARTMENT—CITY OF BALTIMORE G54822

B-87136 CERTIFICATE OF DEATH X 161a

1. PLACE OF DEATH Volunteers of Amer. Hospt. Registered No.

CITY OF BALTIMORE: (No. 418 W. Lexington St. St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Elizabeth Ann Ferig If U. S. Veteran specify WAR

(a) Residence: No. Ridge Road, Eldridge, Md. St., Howard County Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	W	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) Aug 27, 1947

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
			17 hrs.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) | 11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Balto (State or country) Md

FATHER

13. NAME Russell Ferig

14. BIRTHPLACE (city or town) Fire Cetty (State or country) Pa.

MOTHER

15. MAIDEN NAME Elnora Hardy

16. BIRTHPLACE (city or town) Balto (State or country) Md

17. INFORMANT Elnora Ferig
(Address) Eldridge, Md.

18. BURIAL, CREMATION, OR REMOVAL

Place Date 19

19. UNDERTAKER University Medical School AUG 29 1947
(Address)

FILED SEP 3 1947 Commissioner of Health
Registrar.

Huntington Williams, M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Aug 27, 1947

22. I HEREBY CERTIFY, That I attended deceased from Aug 27, 1947 to Aug 27, 1947

I last saw he alive on August 27, 1947. Death is said to have occurred on the date stated above, at 11:00 p.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Congenital Atelectasis	birth
	8.27.47
Other contributory causes of importance:	

Was an operation performed? Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Leonard Gross M. D.

(Address) Volunteers of America Hosp.

X

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G54823

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6C# 87090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G54823 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [redacted]
(c) Hospital or institution: University Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1102 E. Pratt St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Shivers

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	Single

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/17/47

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Edward Lee Shivers

13. Birthplace Greenville, S. Carolina

MOTHER 14. Maiden Name Earleen Moore

15. Birthplace Greenville, S. Carolina

16 (a) Informant Edgar Shivers

(b) Address 1102 E. Pratt St.

17 (a) ..... (b) Date thereof .....
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory .....

Location University Medical School AUG 26 1947

18 (a) Funeral director Commissioner of Health

(b) Address .....

19 (Signature of local registrar) SEP 3 1947 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/20 1947 at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/17 1947 to 8/20 1947, and that I last saw h[illegible] alive on 8/20 1947

Immediate cause of death	Duration
Respiratory Failure	
Due to Pneumonia	1 day
Due to Prematurity	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Stewart M. Williams

Address University Hosp. Date signed 8/20/47

X

G54824

G54824

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Dept 6-86811 159 ✓ G54824 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland.
(b) Street address University Hosp
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 Shields Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clifton Pratt

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: CL
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 8/18/47
8. AGE: Years | Months | Days: 6 | If less than one day: hr. min.
9. Birthplace Univ. Hosp (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Arthur Johnson
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Elizabeth Pratt
15. Birthplace Balto. Md

16 (a) Informant Eliz. Pratt
(b) Address 10B Shields Place

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School AUG 26 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 3 1947 (Date rec'd by registrar) [illegible] M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-24 1947 at 12:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-18-47 19 , to 8-24 1947, and that I last saw him alive on 8-24-47 19 .

Immediate cause of death Respiratory failure - atelectasis — Duration
Due to aspiration of formula
Due to Prematurity
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert R. Hahn M. D.
Address University Hosp Date signed 8-24-

X

G54825 B/F D 87089

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G54825 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~1102 E. Pratt St~~
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1102 E. Pratt St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Shivers

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Color	Single

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/17/47

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Edward Lee Shivers

13. Birthplace Greenville, N. Carolina

MOTHER 14. Maiden Name Earleen Mooring

15. Birthplace Greenville, N. Carolina

16 (a) Informant Earleen Mooring Shivers

(b) Address 1102 E. Pratt St, Balt. Md.

17 (a) ..... (b) Date thereof .....
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory .....

Location University Medical School AUG 26 1947

18 (a) Funeral director Commissioner of Health

(b) Address .....

SEP 3 1947 .....
(Date rec'd by registrar) (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18 19 47 at 7 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-17 1947 to 8-18 1947 and that I last saw him alive on 8-18 19 47

Immediate cause of death	Duration
Respiratory failure	
Due to Pneumonia	1 day
Due to Prematurity	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature Edward M. Williams M.D.

Address University Hospital Date signed 8/18/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54826 BALTIMORE CITY HEALTH DEPARTMENT G54826

CERTIFICATE OF DEATH 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4da.
(e) Length of stay in Baltimore (yrs., mos., or days) 37 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County XXXXXXXXX
(c) City or town City of Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Preston Apartments (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME (Miss) EDITH EARLE STONE

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No.: NONE

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: Single
6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) August 6, 1863

8. AGE: Years 84 | Months 0 | Days 22 26 | If less than one day ..... hr. ..... min.

9. Birthplace: Rutlege, Vermont (Town, county, and state)
10. Usual Occupation: NONE
11. Industry or business: NONE

FATHER
12. Name: William H. Stone
13. Birthplace: New York, New York

MOTHER
14. Maiden Name: Dora D. Dunham
15. Birthplace: Newport, Rhode Island

16 (a) Informant: Mrs. Katharine W. Simpson
(b) Address: Lawrenceville, New Jersey

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Sept. 4, 1947 (month) (day) (year)
(c) Cemetery or crematory: Green Mount
Location: Baltimore, Md.

18 (a) Funeral director: Stewart & Mowen Company
(b) Address: 108 West North Avenue - City 1

19 (a) SEP 3 1947 (Date rec'd by registrar) Huntington Willis (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2 1947, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from August 31 1947, to Sept 2 1947 and that I last saw him alive on Sept 2 1947.

Immediate cause of death: Rupture of heart — Duration: 4 days
Due to: Pulmonary hypostasis & unbalancing
Due to: Coronary thrombosis - occlusion left anterior descending
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Samuel W Bard M.D.
Address: Union Memorial Hosp Date signed: Sept 3

The G54827 BC# 187505 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 159 Registered No. G54827

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3300 - Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 DAY
(e) Length of stay in Baltimore (yrs., mos., or days) 1 DAY

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE
(c) City or town TOWSON 4 (If outside city or town limits, write RURAL and give town)
(d) Street No. WEST ROAD (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME BABY BOY CRANSTON

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 25 AUG 1947

8. AGE: Years	Months	Days	If less than one day
			10 hr. 0 min.

9. Birthplace BALTIMORE (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name ROBERT V. CRANSTON
13. Birthplace MARYLAND

MOTHER
14. Maiden Name FLORENCE ELLEN WAGNER
15. Birthplace KANSAS

16 (a) Informant HOSPITAL RECORDS
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Disposed of by hospital
Location

18 (a) Funeral director
(b) Address

19 (a) SEP 4 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 AUG 1947, at 11:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 25 AUG 1947, to 25 AUG 1947, and that I last saw him alive on 25 AUG 1947.

Immediate cause of death RESPIRATORY FAILURE — Duration
Due to CEREBRAL ANOXIA
Due to PREMATURITY
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Malcolm G. Hunt, M. D.
Address 1211 Monroe St. Date signed 9-2-47

VS 150

G54828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122B

Registered No. G54828

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 627 639 N. Carey St
(c) Hospital or institution: 16-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 627 639 N. Carey St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: ANNA ELIZABETH MILLS

3 (b) If veteran, name war: No

3 (c) Social Security Account No. None

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/7/1909

8. AGE: Years 38 | Months 7 | Days 24 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Typist

11. Industry or business

FATHER
12. Name Royal Hughes
13. Birthplace Va.

MOTHER
14. Maiden Name Mamie Carter
15. Birthplace Va.

16 (a) Informant Mamie Hughes (Mother)
(b) Address 627 639 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location A.A.County, Md.

18 (a) Funeral director Charles G.Cooper
(b) Address 5102 N.Carrollton Ave

19 (a) SEP 4 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/31/47 19 , at 9:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-16 1947 to 8-31 1947 and that I last saw her alive on 8-31 1947

Immediate cause of death: Acute Intestinal Obstruction — Duration 24 hrs.
Due to: Volvulus —
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Franklin Phillips M.D.
Address 1543 Penna. Ave Date signed 9/3/47

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54829

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G54829 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 13
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dont
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1019 W 36th St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert S Shipley

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	213-14-4888

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14, 1882

8. AGE: Years	Months	Days	If less than one day
64	10	18	hr. min.

9. Birthplace Howard County, Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Frank Roach

FATHER
12. Name Alfred Shipley
13. Birthplace Maryland

MOTHER
14. Maiden Name Laura J. McBee
15. Birthplace Washington, D. C.

16 (a) Informant Mac Kearney
(b) Address 1019 West 36th Street

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 9/5/47 (month) (day) (year)
(c) Cemetery or crematory Ivy Hill
Location Laurel, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) SEP 4 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2nd 1947, at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Sclerotic Cardio Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J Kelbach M.D. Medical Examiner.
Date signed Sept 3rd 47

G54830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

G54830 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland ✓
(b) Street address Monument + Rutland
(c) Hospital or institution: Sinai Hospt. 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Unk.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 111 S. Wolfe St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Herman

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Unk
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Unk. Mar 28-1864
8. AGE: Years 83 | Months 5 | Days 5 | If less than one day hr. min.
9. Birthplace Unk. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name
13. Birthplace Unk

MOTHER
14. Maiden Name Unk.
15. Birthplace

16 (a) Informant Deceased
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/6/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem
Location Baltimore

18 (a) Funeral director Wm. Cook, Jr.
(b) Address 1217 St Paul St

19 (a) SEP 4 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-3 1947, at 5A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-29 1947 to 9-3 1947, and that I last saw her alive on 9-3 1947.

Immediate cause of death	Duration
Acute Cardiac Failure	
Due to Coronary Thrombosis	
Due to	
Other Conditions Carcinoma of Uterus	

(Include pregnancy within 3 months of death)
Date of operation 0
Major findings of operation: 0
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M Finberg
Address Sinai Hospt. Date signed 9-3-47 M. D.

94a

G54831 501 Sheridan Ave. — BALTIMORE CITY HEALTH DEPARTMENT — G54831

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 718 East 37th
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City Balto
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 718 East 37th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Katzenberger

3 (b) If veteran, name war

3 (c) Social Security Account No. 137-10-7510

Male | Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband ~~or wife~~ Minnie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12 1885

8. AGE: Years 62 | Months 3 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Salesman Real Estate

11. Industry or business Joseph Marsh Inc

FATHER
12. Name John Katzenberger
13. Birthplace ?

MOTHER
14. Maiden Name Mary J. Malone
15. Birthplace New York

16 (a) Informant Minnie Katzenberger
(b) Address 718 East 37th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/5/47 (month) (day) (year)

(c) Cemetery or crematory Emmanuel Cem
Location Druid Park Ave Balto

18 (a) Funeral director William Cook Jr
(b) Address 217 St Paul Street

19 (a) [illegible] 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2nd 1947 8:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 16 1947, to Sept. 2 1947, and that I last saw him alive on Sept. 1 1947.

Immediate cause of death Cerebral Hemorrhage — Duration 1 day

Due to Hypertensive arterio-sclerotic Condition — Vascular — 5 yrs.

Due to divorce

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. H. Hammond Jr.
Address 501 Sheridan Ave Date signed 2 Sept. 47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54832

DeBullet

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G54832

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 11-
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dna
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 3
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. Latrobe Apts - Charlest Road
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Eugene Gustave de Bullet

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widower

6 (b) Name of husband of Louisa Buchanan

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) May 12 1875

8. AGE: Years	Months	Days	If less than one day
72	6 5	2 1	..... hr. ..... min.

9. Birthplace Cuba
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Francis A. E. de Bullet
13. Birthplace Cuba

MOTHER
14. Maiden Name Carlota Amelia Traub
15. Birthplace Cuba

16 (a) Informant John C de Bullet
(b) Address Blackstone Apts

17 (a) Burial (b) Date thereof Sept 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Green Mount
Location Baltimore Md

18 (a) Funeral director Henry W Jenkins & Son
(b) Address McCulloh & Dolphin Sts

19 (a) SEP 4 1947 (b) Huntington for Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 2 1947, at 1-55 P M

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH ..... Coronary Disease

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 9-3-47

VS 191

X

G54833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G54833

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 12-2
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3317 St Paul St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Alice J. Rockwell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widowed

6 (b) Name of husband or wife Paul Owen Rockwell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-16-99

8. AGE: Years	Months	Days	If less than one day
48	0	18	.....hr. .....min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Psychologist
11. Industry or business

FATHER
12. Name William Rockwell
13. Birthplace Pa.

MOTHER
14. Maiden Name Catherine Hugge
15. Birthplace England

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept 6 1947 (month) (day) (year)
(c) Cemetery or crematory St Marys
Location Belair Md

18 (a) Funeral director Henry W. Jenkins Sons Co
(b) Address McCulloh & Orchard Sts

19 (a) SEP 6 1947 (Date rec'd by registrar) (b) Huntington Willis, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3 1947, at 1240 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 29 1947, to Sept. 3 1947, and that I last saw h alive on Sept. 3 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to Coronary thrombosis	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature H. Brooks M.D.
Address JHH Date signed Sept 4 1947

G54834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BC# 88627 / 157E

Registered No. G54834

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 9 → 2
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 4
(e) Length of stay in Baltimore (~~yrs., mos., or~~ days) 4

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Union Memorial Hosp. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Schoelkopf

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-31-47

8. AGE: Years	Months	Days	If less than one day
		4	hr. min.

9. Birthplace Union Memorial Hospital (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name Jack William Schoelkopff
13. Birthplace Maryland

MOTHER
14. Maiden Name Charlotte Meade
15. Birthplace Maryland

16 (a) Informant Union Memorial Hospital
(b) Address 33 St. Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 4/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location 331 Taylor Ave

18 (a) Funeral director Edwin W. Coughlin & Son
(b) Address 5214 E. Eager St.

19 (Date rec'd by Registrar) SEP 4 1947 Huntington Williamson Mgr.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3 1947 at 3:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 3 1947 to Sept. 3 1947, and that I last saw h[illegible] alive on Sept. 3 1947.

Immediate cause of death Prematurity — Duration

Due to —

Due to —

Other Conditions ? Congenital heart disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ludwig A. Young M. D.
Address Union Memorial Hosp. Date signed 9/3/47

G54835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

G54835 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1021 Somerset St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 74yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1021 Somerset St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry F. Bridge

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anna B. Bridge nee Gentzler 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 22, 1872

8. AGE: Years	Months	Days	If less than one day
75	7	14	hr. min.

9. Birthplace Germany (City or county and state)

10. Usual Occupation Retired Engineer
11. Industry or business Man. of Lunch Room

FATHER
12. Name Henry Bridge
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Weber
15. Birthplace Germany

16 (a) Informant Mrs. Anna B. Bridge
(b) Address 1021 Somerset St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 6, 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Rd.

18 (a) Funeral director Elmer W. Conklin
(b) Address 924 E. Eager St.

19 (Date received by registrar) SEP 4 1947 Signature of Registrar [illegible]

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3, 1947, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 9 1946 to Aug 29 1947 and that I last saw h[illegible] alive on Aug 29 1947.

Immediate cause of death	Duration
Acute Coronary insufficiency	
Due to Coronary Sclerosis	
Due to Ch Myocarditis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature H. G. Hornstein M. D.
Address 733 Cathedral St Date signed 9/3/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G54836 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 610 S. Linwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-2
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt- (If outside city or town limits, write RURAL and give town)
(d) Street No. 610 S Linwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Santa Piscopo

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~Mary~~ Pietro Piscopo
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14 1878

8. AGE: Years 68 | Months 10 | Days 18 | If less than one day ..... hr. ..... min.

9. Birthplace Cefalu' ITALY (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Anthony Citrano
13. Birthplace Italy

MOTHER
14. Maiden Name Domenica
15. Birthplace Italy

16 (a) Informant Pietro Piscopo (Husband)
(b) Address 610 S. Linwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 5th 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Dellacroce
(b) Address 52 N. Morley St.

19 (a) SEP 4 1947 (Date rec'd by registrar) (b) Thurlington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2nd 19..., at 12:20 M.

21. I certify that I took charge of the remains described above, held an Inq Ed Susp Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William C. Gelbach M.D. Medical Examiner.
Date signed Sept 2nd 1947

G54837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

Registered No. G54837

CMK-113498

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1008 Brentwood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Della Stevenson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 12-1865

8. AGE: Years	Months	Days	If less than one day
81	11	21	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ? Goodman
13. Birthplace Maryland

MOTHER
14. Maiden Name ?
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof Sept. 6, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 E. Baddley St.

19 (a) SEP 4 1947 (b) Huntington Williams, M.D.
(Filed by registrar) Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH September 3 1947, at 6:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 2 1947, to Sept. 3 1947, and that I last saw her alive on Sept. 3 1947.

Immediate cause of death	Duration
Superior Mesenteric Thrombosis with Gangrene of Ileum	
Due to Generalized Arteriosclerosis	
Due to	
Other Conditions Cardiac Dilatation	

(Include pregnancy within 3 months of death)

Date of operation Sept. 2, 1947

Major findings of operation: Gangrene of 3ft lower ileum

of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rush E. Netterville, M.D.
Address Balt. City Hosp. Date signed Sept 3, 47

VS 150

X

G54838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G54838 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2212 Prentiss Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2212 Prentiss Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cora Bell Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Noah Hill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26 1880

8. AGE: Years	Months	Days	If less than one day
66	11	7	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Smart

13. Birthplace Balto Md

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Mrs Minnie McCarthy

(b) Address 2403 E Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-6-47 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cem

Location Belair Road

18 (a) Funeral director John C Melly Sr

(b) Address 2437 E Oliver St

19 (a) Sept 6 1947 (Date received by registrar) (b) Huntington Williams M.D. Registrar

20. DATE OF DEATH September 2 1947, at 2:45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1947, to Sept 2 1947, and that I last saw her alive on Sept 1 1947.

Immediate cause of death Coronary Thrombosis — Duration 5 hrs.

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify nature of place)
(e) Means of injury
23. Signature David Schneider

Address 110 N. Milton Ave Date signed 9-3-47 M. D.

VS 150

G54839

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

Registered No. G54839

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 304 Regester Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Otto K. Warner

3 (b) If veteran, name war: 7/0
3 (c) Social Security Account No. 218-07-8264

4. Sex: M
5. Color or race: W
6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~. Married
6 (b) Name of husband or wife: Mary Ellen Warner
6 (c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.) May 8-1917

8. AGE: Years 30 | Months 3 | Days 4 | If less than one day: hr. min.

9. Birthplace Iowa (Town, county, and state)
10. Usual Occupation Supervisor
11. Industry or business Western Electric
FATHER 12. Name Otto K. Warner Sr.
13. Birthplace —
MOTHER 14. Maiden Name Faith Bellis
15. Birthplace —

16 (a) Informant Mrs Mary Ellen Warner
(b) Address 7105 Loch Hill Rd
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 5-1947 (month) (day) (year)
(c) Cemetery or crematory St Mary's
Location Towson Md.
18 (a) Funeral director John Bruzzalone
(b) Address 1407 York Rd Towson 4
19 (a) SEP 4 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2, 1947 at 10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Lobar pneumonia
Acute urinary tract infection
Due to
Other Conditions Multiple fractures of pelvis Fracture Rt. femur & Lumbar etc.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8/26/47 at 27/12 3:15 A.M.
(b) Where did injury occur? York Rd + Lyman Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Auto struck safety pylon
23. Signature Earl L. Royer M.D. Medical Examiner
Date signed 9-3-47

VS 151

G54840

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G54840

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Millersville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rachel Raynor (RACHEL AMELIA RAYNOR)

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	M

6 (b) Name of husband or wife John B. Raynor
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) March 15, 1900

8. AGE: Years	Months	Days	If less than one day
47	5	17	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name David Harnell
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Hood
15. Birthplace Penna.

16 (a) Informant John B. Raynor
(b) Address Millersville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/6/47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Annapolis Rd. Balto, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) SEP 4 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2 1947, at 7:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1947 to Sept 2 1947 and that I last saw h.e.r. alive on Sept 2 1947

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension

Due to

Other Conditions Diabetes

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Diabetes Mellitus

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. L. Nelson Taylor M. D.
Address Mercy Date signed 9-2-47

G54841

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V115D

Registered No. G54841

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Josephs Hospital 2nd
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 74 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3603 Echodale Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA M. LAWRENCE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	WIDOW

6 (b) Name of husband or wife Harry H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/21/73

8. AGE: Years	Months	Days	If less than one day
73 74	8	13	hr. min.

9. Birthplace Baltimore - Md. (Town, county, and State)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph C. Doll
13. Birthplace N.J.

MOTHER
14. Maiden Name Louise Lepper
15. Birthplace Pa.

16 (a) Informant Mrs. Arthur Schmalbeck
(b) Address 3603 Echodale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-6-47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 520 S. Stafford Road.

19 (Date received by registrar) 1947 (Signature of Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 - 3 - 1947 at 6 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-30-1947 to 9-3-1947 and that I last saw h[illegible] alive on 9-3-1947

Immediate cause of death Cardiac failure — Duration

Due to Hypertensive Cardio Vascular disease

Due to

Other Conditions Obesity, Suppurative parotitis

(Include pregnancy within 3 months of death)

Date of operation 8-31-47

Major findings of operation: Suppurative parotitis, Left

Autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stanley B. Kyriakos M.D.
Address 520 St. Josephs Hosp. Date signed 9/5/47

VS 150

G54842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V937

Registered No. G54842

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 801 E 33rd St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) **FULL NAME** Alphonse L Beuret (ALPHONSE L. BEURET)

3 (b) If veteran, name war: World War I.

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sarita C. Beuret

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 31, 1892

8. AGE: Years 55 | Months 5 | Days 3 | If less than one day ..... hr. ..... min.

9. Birthplace Fort Wayne, Indiana (Town, county, and state)

10. Usual Occupation Assistant Purchasing Agent

11. Industry or business Maritime Commission

FATHER
12. Name Henry J. Beuret
13. Birthplace Indiana

MOTHER
14. Maiden Name Caroline Derwald
15. Birthplace Indiana

16 (a) Informant Sarita C. Beuret
(b) Address 607 Park Ave. Salisbury, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-8-47 (month) (day) (year)
(c) Cemetery or crematory Fort Wayne
Location Fort Wayne Indiana

18 (a) Funeral director George L. Shivat
(b) Address 3101 Frederick Ave.

19 (a) SEP 4 1947 (Date rec'd by registrar) (b) Huntington-Williams Mort.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 3 1947, at 9:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1947 to Sept 3 1947 and that I last saw h. alive on Sept 3 1947

Immediate cause of death	Duration
Coronary occlusion	1 hr.
Due to Arteriosclerotic Heart Disease.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Norman R. Freeman M.D.
Address Union Memorial Hospital Date signed Sept 3, 1947
For A. W. B. Helford by Howard J. Andersen M.D.

G54843 CHK-110471

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G54843 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Months
(e) Length of stay in Baltimore (yrs., mos., or days) 3 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No streetaddress given (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond Trumbo

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 7-1882

8. AGE: Years 65 | Months - | Days 27 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Trumbo
13. Birthplace Maryland

MOTHER
14. Maiden Name Gertrude DeButts
15. Birthplace Virginia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/6/47 (month) (day) (year)
(c) Cemetery or crematory Family Plot
Location Front Royal Va

18 (a) Funeral director Fun't Mar Gabbett
(b) Address Catonsville Md

19 (a) SEP 4 1947 (Date rec'd by registrar) (b) Huntington for Williams Registrar

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH September 3 19 47 at 1:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 6 1947, to Sept. 3 1947, and that I last saw him alive on Sept. 3 1947.

Immediate cause of death	Duration
Hypertensive Cardio Vascular disease	?
Due to	
Due to	
Other Conditions Nephrosclerosis Generalized arteriosclerosis	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard T. Binford, M. D.
Address Balt. City Hosp. Date signed 9-4-47

X

G54844

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G54844

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla (b) County
(c) City or town Arcadia (If outside city or town limits, write RURAL and give town)
(d) Street No. 501 Arcadia Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Betty J. Lanier

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-25-33

8. AGE: Years 14 | Months 13 | Days - | If less than one day hr. min. 9

9. Birthplace Florida (Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name Joseph C. Lanier
13. Birthplace Florida

MOTHER
14. Maiden Name Mittie Lee King
15. Birthplace Florida

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-8-47 (month) (day) (year)
(c) Cemetery or crematory ARCADIA
Location Arcadia-Fla

18 (a) Funeral director Durant Memorial Co.
(b) Address 1818 Northern.

19 (a) SEP 4 1947 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 3 1947 at 4:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 24 1947 to Sept 3 1947 and that I last saw h.. alive on Sept 3 1947

Immediate cause of death: Respiratory arrest — Duration:
Due to: Dermatomyositis
Due to:
Other Conditions: Inanition, Hookworm

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sherman M. Mellinkoff M. D.
Address Johns Hopkins Hospital Date signed 9/4/47

156 B

G54845

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122 B

G54845
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore Genl Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4733 Beaufort ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Dana (Julia Elnora Davis)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband ~~or wife~~ late Henry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12, 1868

8. AGE: Years 79 Months 4 Days 21 If less than one day hr. min.

9. Birthplace Front Royal Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Henry Moffett
13. Birthplace Virginia

MOTHER
14. Maiden Name Fannie Hope
15. Birthplace South Carolina

16 (a) Informant Mr. James H. Davis
(b) Address 181 Kenneth Ave - Baltimore - Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 6 1947 (month) (day) (year)
(c) Cemetery or crematory Middletown
Location Middletown Virginia

18 (a) Funeral director Henry H Wolfe
(b) Address 4101 Edmondson Ave

19 (a) SEP 4 1947 (Date rec'd by registrar) (b)
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3 1947, at 10 45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 2 1947 to Sept. 3 1947, and that I last saw her alive on Sept. 3 1947.

Immediate cause of death Respiratory collapse — Duration
Due to Cachexia
Due to Vomiting from ulcer of Duodenum, Carcinoma
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm Goldstein M. D.
Address West Balto. Md. Date signed 9/4/47

X

G54846 — BALTIMORE CITY HEALTH DEPARTMENT — G54846 Registered No.

CERTIFICATE OF DEATH 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2119 Ramsay st
(c) Hospital or institution: [illegible]
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2121 Mc Henry st. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry E. Carroll

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8 1881

8. AGE: Years 66 | Months 5 | Days 6 25 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business Jewish Memorial Hosp.

FATHER
12. Name Albert Carroll
13. Birthplace Md

MOTHER
14. Maiden Name Laura Creamer
15. Birthplace Md

16 (a) Informant Eugene Curley
(b) Address 2121 Mc Henry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 5 1947 (month) (day) (year)
(c) Cemetery or crematory Loud Cathedral
Location Old Frederick Rd

18 (a) Funeral director Henry H Wittyle
(b) Address 4101 Edmondson Ave

19 (a) 1947 (Date rec'd by registrar) (b) Courtney for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2nd 1947, at 3 45 P.M

21. I certify that I took charge of the remains described above, held an Insp. & Inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Malkus M.D. Medical Examiner.
Date signed Sept 3, 1947

VS 151

G54847

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83 B

G54847
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3610 Parkside Drive
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 78 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3610 Parkside Drive (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Edward Schuh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Bernice Schuh

6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) February 11, 1869

8. AGE: Years 78 | Months 6 | Days 22 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Pharmacist

11. Industry or business Self

FATHER — 12. Name Edgar Schuh
13. Birthplace Germany

MOTHER — 14. Maiden Name Wilhelmina Buck
15. Birthplace Germany

16 (a) Informant Mrs. Bernice Schuh
(b) Address 3610 Parkside Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 5 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Baltimore

18 (a) Funeral director J. M. Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) SEP 5 1947 (Date received by registrar) (b) Huntington-Williams Mfg. Co.

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 2 1947, at 6:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1st 1947 to Sept 2nd 1947, and that I last saw him alive on Sept 2nd 1947.

Immediate cause of death	Duration
Cerebral thrombosis, recurrent	48 hrs
Due to Generalized arteriosclerosis	3 yrs
Due to	
Other Conditions Spastic hemiplegia left (Include pregnancy within 3 months of death)	3 yrs.

Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frederick J. Vollmer M. D.
Address 6100 York Road Date signed Sept 2 '47

G54848

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

G54848 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 31 S. Stricker St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 31 S. Stricker St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3. (a) FULL NAME Charles, G. Russell (Raskevicius)
3 (b) If veteran, name war ✓
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Agnes
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1877
8. AGE: Years: 70 | Months | Days | If less than one day: hr. min.
9. Birthplace: Lith. (Town, county, and state)
10. Usual Occupation: Tailor
11. Industry or business

FATHER
12. Name: ?
13. Birthplace: Lith.

MOTHER
14. Maiden Name: ?
15. Birthplace: Lith

16 (a) Informant: Agnes Russell
(b) Address: 31 S. Stricker St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept (month) 4 (day) 47 (year)
(c) Cemetery or crematory: Holy Redeemer Cem
Location: Belair Rd
18 (a) Funeral director: Joseph Kazinskas
(b) Address: 602 W Lexington St
19 (a) SEP 5 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/1 1947 at 2 M
21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 1947 to 9/1/47 1947, and that I last saw him alive on 9/1 1947.

Immediate cause of death: Carcinoma of bladder — Duration: 6 mos.
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Benjamin Miller M. D.
Address: 2030 Wilkens Ave Date signed: 9/3/47

G54848 Registered No.

G54849 BOH B-8402 **BALTIMORE CITY HEALTH DEPARTMENT** G54849

CERTIFICATE OF DEATH 157E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 731 S Charles Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alline DANELES

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/17/47

8. AGE: Years | Months 1 | Days 15 | If less than one day 6 hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Charlie Daniels
13. Birthplace N.C.

MOTHER 14. Maiden Name Mary Mason
15. Birthplace Va.

16 (a) Informant Mary Daniels
(b) Address 731 S. Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-5-47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A. C. Co, Md

18 (a) Funeral director Daniel L Brown & Son
(b) Address 108 W Monument St

19 (a) SEP 5 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 151-

MEDICAL CERTIFICATION 30

20. DATE OF DEATH September 1, 1947, at 7 a. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Congenital heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 9/1/47

G54850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30 E

Registered No. G54850

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edward + Jane Sts. 18
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1 N Amity St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Randolph Stokes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/19/1908

8. AGE: Years 38 | Months 8 | Days 14 | If less than one day ..... hr. ..... min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Cigarmaker

11. Industry or business Tobacco

FATHER
12. Name James Stokes
13. Birthplace N C

MOTHER
14. Maiden Name Carrie Arrington
15. Birthplace N C

16 (a) Informant Roberta Stokes
(b) Address 1 N Amity St

17 (a) Burial (b) Date thereof 9-7-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A a Co Md

18 (a) Funeral director Isaiah L Abramson
(b) Address 1 S & W Mount Royal Ave

SEP 5 1947 (Date rec'd by registrar) (Huntington Williams M.D.)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2 1947, at 4 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 2 1947, to 9-2 1947, and that I last saw h[illegible] alive on Sept 2 1947.

	Duration
Immediate cause of death Respiratory and Circulatory Failure	
Due to Syphilitic Cardiovascular Disease & Cardiac insufficiency & Arteriosclerosis	
Due to Mitral Insufficiency Cardiac Hypertrophy & Dilatation	
Other Conditions Chronic asthma Impending pneumonia.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sidney N. Sacks M. D.

Address Univ. Hospital Date signed 9/3/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G54851

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1616 E. Chase St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 E. Chase St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miriam Tampakow

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1859

8. AGE: Years 88 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Isadore Lesnikoff
(b) Address 3622 Dolfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-5-47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location

18 (a) Funeral director Jack Leshin Inc
(b) Address 2100 Eutaw Place Baltimore, Md

19 (a) SEP 5 1947 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 - 4 - 1947 at 5:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-3- 1947 to 9-4- 1947. and that I last saw h[illegible] alive on 9/4 1947.

Immediate cause of death	Duration
Cerebral pneumonia	
Due to Malignancy	
Due to	
Other Conditions Ch Pulmonary Th	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature A. L. Hornstein M. D.
Address 733 Argyle St Date signed 9-4-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G54852 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1178 N. Gilmor St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50y

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1178 Gilmor St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: col | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Richard Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years: 69 | Months | Days | If less than one day: hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Mr. Edwin Snell
13. Birthplace: Balto. Md

MOTHER
14. Maiden Name: Isabella Johnson
15. Birthplace: Balto. Md.

16 (a) Informant: Mrs. Sarah Shelton
(b) Address: 2009 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/6/47 (month) (day) (year)
(c) Cemetery or crematory: Arbutus Cem.
Location: Halethorpe Md.

18 (a) Funeral director: Metropolitan Funeral Home Inc.
(b) Address: 917 N. Monroe St.

19 (a) (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-2- 1947, at 10 P. M

21. I certify that death occurred on the date above stated that I attended deceased from 6/2 1947 to 9/2 1947, and that I last saw h[illegible] alive on 8/29 1947.

Immediate cause of death	Duration
Chronic Cardiovascular Renal disease	
Due to Hypertension	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1200 Eutaw Place Date signed 9/4/47

VS 150

G54853 | BALTIMORE CITY HEALTH DEPARTMENT | G54853 Registered No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 25-2
(c) Hospital or institution: South Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. McCullough St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James McKinnon (McKinley)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years 45 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER
12. Name Chas. Cummings
13. Birthplace N. C.

MOTHER
14. Maiden Name Gaggla Chisal
15. Birthplace N. C.

16 (a) Informant Charles Cummings.
(b) Address 427 Swade Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/5/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co. Md.

18 (a) Funeral director Metropolitan Funeral Home
(b) Address 923 N. Mount St.

19 (a) 9/5/47 (Date Rec'd by registrar) (b) Huntington-Williams, Md.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2 1947, at 10:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertrophy and acute dilatation of the Heart; Congestion and fatty changes of Liver; Edema and Congestion of Lungs; Early nephrosclerosis

Other Conditions Atherosclerosis of aorta; Softening of the frontal lobe of brain

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mallis M.D.
Medical Examiner.
Date signed 9-2-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

B-54854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

B-54854
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1624 E Oliver St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) -
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1624 E. Oliver St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Francis X. Bailey

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 212-05-0544

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Grace G. Bailey
6 (c) If alive, give age years
If Yes, give maiden name

7. Birth date of deceased (mo., day, yr.) Nov 28, 1889

8. AGE: Years 57 | Months 9 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Manufacturer Mgr
11. Industry or business C & P Telephone Co.

FATHER
12. Name John A. Bailey
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Rose Ann Reynolds
15. Birthplace Baltimore Md

16 (a) Informant Mrs Grace G. Bailey
(b) Address 1624 E. Oliver St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 10, 1947 (month) (day) (year)
(c) Cemetery or crematory Westminster Cemetery
Location Westminster Md.

18 (a) Funeral director Edgar W. Castlemen
(b) Address 924 E. Eager St Baltimore Md

19 (a) SEP 8 1947 (Date rec'd by registrar) (b) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7, 1947 at 3:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 19th, 1947 to Sept. 7th, 1947.
and that I last saw h in alive on Sept. 6, 1947.

Immediate cause of death	Duration
Myocardial Insufficiency	3 yrs.
Due to ------- -	
Due to -------	
Other Conditions Endocarditis	3 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury Mergatroyd
23. Signature Geo. W. Mergatroyd M.D.
Address 401 E. 25th. St. Date signed 9/8/47.

X

G54855

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146 B

G54855 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution Sinai 23-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 1200 Bo Hanover St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IDA HENESON.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Hyman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years 59. | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Morton
13. Birthplace Russia

MOTHER
14. Maiden Name Leah
15. Birthplace Russia

16 (a) Informant Hyman Heneson
(b) Address 1200 Bo Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-10-47 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Mt Carmel

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) SEP 10 1947 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/9 1947, at 4:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/4 1947 to 9/9 1947 and that I last saw h[illegible] alive on 9/9 1947

Immediate cause of death Carcinomatosis — Duration 4 Wks.

Due to Ca. of Stomach —

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation May 47.

Major findings of operation: Carcinoma (generalized)

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Orren Kaufman M. D.
Address Sinai Hospital Date signed 9/6/47

G54856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G54856

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1343 N.Carey St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1343 N.Carey St
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME (ELEANORA) NELLIE BOYD

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Edward
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/28/1875

8. AGE: Years 71 | Months 9 | Days 3 | If less than one day ....hr. ....min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Louis Wicks
13. Birthplace Md

MOTHER
14. Maiden Name Marie Howard
15. Birthplace Md

16 (a) Informant Edward Boyd (Husband)
(b) Address 1343 N.Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/5/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N.Carrollton Ave

SEP 5 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Address 1 W. Mad. St

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2nd, 1947, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-23 1947 to 9/2 1947 and that I last saw h[illegible] alive on 9/1 1947.

	Duration
Immediate cause of death: Cerebral hemorrhage	10 Days
Due to: hypertensive cardio-renal disease	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Rayner Browne M.D.
Address 1 W. Mad. St Date signed 9/4/47

X

G54857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G54857 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 819 S. Linwood Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 819 S. Linwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Plociennik

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Helen

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) March 14 1895

8. AGE: Years 52 | Months 5 | Days 21 | If less than one day ..... hr. ..... min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name Mateusz Plociennik

13. Birthplace Poland

MOTHER 14. Maiden Name Franciszka Mileska

15. Birthplace Poland

16 (a) Informant Helen Plociennik

(b) Address 819 S Linwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/6/47 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart of Mary

Location German Hill Rd.

18 (a) Funeral director John J. Duda

(b) Address 2829 Eastern Ave

SEP 5 1947 (Date rec'd by registrar) Registrar for Millington, Md.

VS 151

MEDICAL CERTIFICATION 9/4/47

20. DATE OF DEATH September 1947 at 10 a.m. P.M. 45

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to Advanced Arteriosclerosis

Other Conditions Chronic myocarditis, mural thrombus.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Thomsen M.D. Medical Examiner.
Date signed 9-4-47

G54858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G54858
Registered No.

433124 309

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1433 Eastern Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Zant. ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	Col.	married

6 (b) Name of husband or wife Julius C. Zant
6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) 7-15-92

8. AGE: Years	Months	Days	If less than one day
6-5-	1	17	hr. min.

9. Birthplace S. C. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Alex Laughton
13. Birthplace S. C.

MOTHER
14. Maiden Name Augusta Forrest
15. Birthplace S. C.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 5-1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co. Md.

18 (a) Funeral director Byron Thomas McWright
(b) Address 721 Saratoga St.

19 (a) SEP 5 1947 (date received) Huntington Williams M.D. (registrar)

V S-150 **-**-1A

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1 - 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-20- 1947 to 9-1- 1947 and that I last saw her alive on 9-1- 1947

Immediate cause of death	Duration
Uremia	6 months
Due to Hypertensive cardiovascular renal disease	
Due to Arteriosclerosis	
Other Conditions Lesion of jaw and lip of unknown cause. Epithelioma	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Hoff
Address Johns Hopkins Hosp. Date signed Sept 5 '47 M.D.

131a

G54859

Jackson

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V12B

G54859
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 507 N. Fremont Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 507 N. Fremont Ave.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Jackson Ford.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F. | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ernest Ford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/28/1912

8. AGE: Years 54 | Months 9 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name ✓ Unobtainable
13. Birthplace ✓

MOTHER 14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant Corrine Thomas
(b) Address 507 N. Fremont Ave

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 9/6/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. B. Nelson
(b) Address 1303 Pennsylvania Ave

19 (a) SEP 5 1947 (Date received by registrar) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5 1947, at 3:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 5 1947, to Sept 5 1947, and that I last saw her alive on Sept 5 1947.

Immediate cause of death	Duration
Tuberculosis	
Due to Tuberculous Organism	
Due to	
Other Conditions Malnutrition	

(Include pregnancy within 3 months of death)
Date of operation No
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. W. Anderson M.D.
Address 1536 W. Lanvale Date signed 9-4-47
M. D.

X

ELINORA

G54860

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G54860

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 510 S. Caroline St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 510 S. Caroline St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elnora R. Washington

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-09-6023

4 Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Joseph Washington

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 29 189[illegible]

8. AGE: Years	Months	Days	If less than one day
53	-	13	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Factory Worker

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant Alvin Burroughs

(b) Address 510 S. Caroline St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 5 47 (month) (day) (year)

(c) Cemetery or cremator Mt Calvary Cem, Location Brooklyn, Md

18 (a) Funeral director Elwood O. Wilson

(b) Address 1010 Belnord Ave

19 (a) SEP 5 1947 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5 1947, at 1:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 11 1947 to Sept 5 1947 and that I last saw him alive on Aug 17 1947

Immediate cause of death: Valvular heart disease — Duration 6 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Manner of injury

23. Signature Samuel A. Bernstein M.D.

Address 3611 Bell Blvd Date signed Sept 6 1947

VS 150

G54861

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G54861 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1012 E. Monument St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1012 E. Monument St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Henry Harris

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-10-2209

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Separated

6 (b) Name of husband or wife Isabella Harris
6 (c) If alive, give age 24 years

7. Birth date of deceased (mo., day, yr.) July 14, 1915

8. AGE: Years	Months	Days	If less than one day
32	1	18	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Macos Harris
13. Birthplace Va.

MOTHER
14. Maiden Name Laura Hill
15. Birthplace Va.

16 (a) Informant Laura Hill
(b) Address 1012 E. Monument St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/5/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location Brooklyn, Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly Ave.

19 (a) SEP 5 1947 (Date rec'd by registrar) (b) Hamilton Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/2 1947 at 9 N A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/10 1947 to 9/2 1947 and that I last saw h[illegible] alive on 8/29 1947

Immediate cause of death Pulmonary Tuberculosis (Advanced)

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
UNK.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Rayner Browne

Address 1510 E. Mon. St Date signed 9/4/47

Rayner Browne X

G54862 DCH G-90501 CWK-113462

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G54862

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) About 5 Hours
(e) Length of stay in Baltimore (yrs., mos., or days) About 5 Hours

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town [redacted] Lutherville
(If outside city or town limits, write RURAL and give town)
(d) Street No. None Given
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Smith- (Maudie)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1-1947

8. AGE: Years | Months | Days | If less than one day: 4 hr. 35 min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Smith
13. Birthplace Maryland

MOTHER
14. Maiden Name Maudie Fields
15. Birthplace South Carolina

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Cremation (b) Date thereof 9-3-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Crematory
Location 4940 Eastern Avenue

18 (a) Funeral director
(b) Address

19 (a) SEP 5 1947 (b) Huntington Williamsport Md.
(Date rec'd by Reg'r)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1 1947, at 11:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1 1947 to Sept. 1 1947, and that I last saw her alive on Sept. 1 1947.

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions Fetal atelectasis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. H. Becker

Address Balto City Hosp Date signed 9/2/47 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C54863

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

C54863 Registered No.

1310

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Providence Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1045 Cathedral St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Emma Bradford

3 (b) If veteran, name war — 3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife James

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1873

8. AGE: Years 73 | Months 11 | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Caterer

11. Industry or business

FATHER 12. Name Benjamin Simpson
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Emma Smith
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Howard Murphy
(b) Address 2410 Mitchell Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 5, 1947 (month) (day) (year)
(c) Cemetery or crematory Dolphin Glen Cem. Co.
Location Baltimore Co. Md.

18 (a) Funeral director Wm. Geo. H. Sullivan
(b) Address 1691 Druid Hill Ave.

19 SEP 5 1947 (Date rec'd by registrar) (Signature) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-3-1947, at 5 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1934 to 9-3 1947 and that I last saw him alive on 9-3 1945

Immediate cause of death	Duration
Cardiac Decompensation Chronic	
Due to Cardio-vascular Renal Disease	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. W. Butler

Address 2633 Druid Hill Ave Date signed 9/5/47

G54864

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947a

Registered No. G54864

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1629 N. Spring Street
(c) Hospital or institution: 1

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1629 N. Spring Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louisa Utz (Louisa M. Utz)

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: George Utz

6 (c) If alive, give age: D years

7. Birth date of deceased (mo., day, yr.): Aug. 29, 1868

8. AGE: Years: 79 | Months: 0 | Days: 4 | If less than one day: ____ hr. ____ min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: William Blotkamp
13. Birthplace: Holland

MOTHER
14. Maiden Name: Elizabeth ?
15. Birthplace: Holland

16 (a) Informant: George T. Utz (Son)
(b) Address: 1629 N. Spring Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/47 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Rd. Balto: Md.

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) SEP 5 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 Sept. 1947, at 11:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic coronary disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer Jr. M.D. Medical Examiner.
Date signed 4 Sept. 47

X

G54865 LW 112266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G54865

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1327 W. Pratt St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stephan Michasuk or Stepan Michael Michasuk

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Know ?

8. AGE: Years 57 ? | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retirement

11. Industry or business Railroad

FATHER
12. Name Metrofan
13. Birthplace Russian

MOTHER
14. Maiden Name Tityna
15. Birthplace Russia

16 (a) Informant B.C.H.Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 6. 47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road

18 (a) Funeral director John a Grebliauckas Jr
(b) Address 423 S. Paca Street,

19 SEP 5 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3 1947, at 11:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-18 1947, to 9-3- 1947 and that I last saw him alive on Sept. 3 1947.

Immediate cause of death: Bronchopneumonia — Duration 72 hrs

Due to:

Due to: (a) Hypertensive arteriosclerotic Cardio-vascular disease. (b) Benign prostatic hypertrophy

Other Conditions: Generalized arteriosclerosis.

(Include pregnancy within 3 months of death)

Date of operation 8/25/47

Major findings of operation: Bilateral orchiectomy

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. L. Gibbs

Address Balt. City Hosp. Date signed M 7 D 3/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54866

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1637

Registered No. G54866

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Do. Ad
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2469 Westport Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John (Lehera) Libera

3 (b) If veteran, name war —
3 (c) Social Security Account No. 218-01-5787

4. Sex: Male
5. Color or race: White
6 (a) ~~Single~~, married, ~~widowed, divorced~~.
6 (b) Name of husband or wife: Sarah J
6 (c) If alive, give age 57 years
7. Birth date of deceased (mo., day, yr.) June 24 1891
8. AGE: Years 56 | Months 2 | Days 10 | If less than one day ____ hr. ____ min.
9. Birthplace Hungaria (Town, county, and state)
10. Usual Occupation Cooper
11. Industry or business

FATHER
12. Name Steven Libera
13. Birthplace Hungaria

MOTHER
14. Maiden Name Unknown
15. Birthplace Hungaria

16 (a) Informant Mrs. Sarah J. Libera
(b) Address 2469 Westport St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/47 (month) (day) (year)
(c) Cemetery or crematory Green Haven
Location Reisterstown Hwy
18 (a) Funeral director Edward H. Lawlor
(b) Address 2359 Wash. Blvd.
19 (a) SEP 5 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-4-1947, at 1:38 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Illuminating gas

Other Conditions Drunkenness

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9/4/47 at 1:30 P.M.
(b) Where did injury occur? 2469 Westport Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Kitchen range unlit & gas turned on

23. Signature Howard J. Thurston M.D.
Medical Examiner.
Date signed 9-4-47

G54867

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G54867

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 903 N. Kenwood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 903 N. Kenwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER JOSEPH GATES

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. 716-12-2824

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bessie May Gates
6 (c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): July 7, 1887

8. AGE: Years: 60 | Months: 1 | Days: 27 | If less than one day: ..... hr. ..... min.

9. Birthplace: Wisconsin (Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business: Penna. R.R.

FATHER
12. Name: Abraham Gates
13. Birthplace: Wisconsin

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Wisconsin

16 (a) Informant: Mrs. Bessie M. Gates - WIDOW
(b) Address: 903 N. Kenwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/6/47 (month) (day) (year)
(c) Cemetery or crematory: Meadowridge Cem.
Location: Elkridge, Md

18 (a) Funeral director: HENRY SANDER & SONS, INC
(b) Address: NORTH AVE. & BROADWAY

19 (a) SEP 5 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION AM

20. DATE OF DEATH September 4 1947, at 6.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19[illegible] to Sept 4 1947.
and that I last saw h[illegible] alive on Sept 3 1947.

	Duration
Immediate cause of death: Coronary Thrombosis	1 year
Due to: Hypertension	20 years
Due to:	
Other Conditions: Diabetes Mellitus	3 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Edward J. Sikorsky M. D.
Address: 937 N. Kenwood Ave Date signed 9/4/47

G54868

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G54868

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2316 Lyndhurst Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2316 Lyndhurst Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lester Wallace

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Letitia Bowersox
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Aug. 28, 1872

8. AGE: Years	Months	Days	If less than one day
75	—	6	..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Banker
11. Industry or business

FATHER
12. Name Samuel S. Wallace
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Miriam P. Tindall
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Letitia B. Wallace
(b) Address 2316 Lyndhurst Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/6/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell & Sons Inc.
(b) Address 1900 Eutaw Place

SEP 5 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3 1947 at ..... M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to Sept 3 1947, and that I last saw h~~e~~ alive on Sept 3 1947.

Immediate cause of death	Coronary Thrombosis		Duration
Due to	arteriosclerosis and repeated strokes		
Due to	Coronary Thrombosis		
Other Conditions	Heart decompensation		

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [redacted] M.D.
Address [redacted] Date signed Sept 4 '47

VS 150

3033 W. North Ave. X

G54869

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

G54869 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1705 Ellsworth St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Alma

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25 1910

8. AGE: Years 37 | Months 7 | Days 9 | If less than one day hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Shadrack Taylor

13. Birthplace N. C.

MOTHER 14. Maiden Name Sallie Mossie

15. Birthplace N. C.

16 (a) Informant Alma Taylor

(b) Address 1705 Ellsworth St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept 6/47 (month) (day) (year)

(c) Cemetery or crematory Location Charlotte, N. C.

18 (a) Funeral director Mrs. Lott & Ellington

(b) Address 1129 N Eutaw St

19 (a) SEP 5 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3, 1947, at 2 15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH Bullet Wound of Heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 9/3/47 at 3 45 P.M.

(b) Where did injury occur? Front of 1921 E. Biddle

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Firearm

23. Signature Earl L. Ryan M.D. Medical Examiner.

Date signed 9-4-47

VS 131

G54870

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 461

Registered No. G54870

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Born Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 Born Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Laura Snell Duncan.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Horace Duncan.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7, 1882.

8. AGE: Years 65 | Months 5 | Days 27 | If less than one day hr. min.

9. Birthplace Lonaconing, Md.. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Dennis Snell.
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine ?
15. Birthplace Md.

16 (a) Informant Laura Reddick.
(b) Address 1406 Born Court.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-6-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Kate R. Williams
(b) Address 322 N. Schroeder St

19 (a) SEP 5 1947 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3 1947, at 9:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 29 1947, to Sept 3 1947, and that I last saw her alive on Sept 2 1947.

Immediate cause of death: Carcinoma of Rectum — Duration: March 1947

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eliot W. Johnson

Address 3432 Linden Ave Date signed 9/4/47 M D

X

G54871

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G54871

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green Sts.
(c) Hospital or institution:
University of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Gambrills, R.F.D.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Millersville Ft. Meade Road
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK JOSEPH FINK

3 (b) If veteran, name war

3 (c) Social Security Account No. Unknown

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Josephene Fink Nee Tucker
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) May 25, 1888

8. AGE: Years	Months	Days	If less than one day
59	4 3	10	....hr. ....min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business Ft. Meade(Civil service)

FATHER
12. Name Louis Fink
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Rebecca Rider
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Frank J. Fink
(b) Address Gambrills, Md.

17 (a) Burial (b) Date thereof Sept. 8, 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Marys
Location Annapolis, Md.

18 (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie, Md.

19 (a) Sep 5 1947 (b) Huntington Williams Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5 1947, at 2 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/30 1947 to 9/5 1947, and that I last saw h/ alive on 9/5 1947

Immediate cause of death	Duration
Pneumonia	10 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Helen Doerges M. D.
Address University Hosp. Date signed 9/5/47

G54872

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G54872

D87706 159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Caton Ave
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 55 min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3710 East Fombell Av.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Barry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/1/47

8. AGE: Years | Months | Days | If less than one day: hr. 55 min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Wiley Barry
13. Birthplace

MOTHER
14. Maiden Name Lena Miscucci
15. Birthplace Ohio

16 (a) Informant St. Agnes Hospital
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 5 47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Holy Redeemer
Location Belair Rd. Balt. Md

18 (a) Funeral director Brault Dellatore
(b) Address 52 N. Morley St

19 (a) SEP 5 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/1/47 19 , at A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1/47 19 , to 9/1/ 19 47
and that I last saw her alive on 9/1/ 19 47

Immediate cause of death	Duration
Respiratory failure	
Due to prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles V. Bowen, Jr. M.D.
Address St. Agnes Hospital Date signed 9/5/47

X

G54873 — P87707

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

Registered No. G54873

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 Caton Ave.
(c) Hospital or institution St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 55 Min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3710 East Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Barry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F.

5. Color or race: White

6 (a) Single, ~~married, widowed,~~ or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/1/47

8. AGE: Years | Months | Days | If less than one day: hr. 55 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER — 12. Name Finley Barry

FATHER — 13. Birthplace

MOTHER — 14. Maiden Name Lena Micucci

MOTHER — 15. Birthplace Ohio

16 (a) Informant St. Agnes Hospital

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 5 47 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Relgis Rd. Balt. Md

18 (a) Funeral director Frank Della Vecchia

(b) Address 524 N. Wesley Ave

19 SEP 5 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/1/47 19 , at A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 1947 to 9/1 1947, and that I last saw her alive on 9/1 1947.

Immediate cause of death Respiratory failure

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles J. Bowen Jr. M.D.
Address St. Agnes Hosp. Date signed 9-5-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54874

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 M

Registered No. G54874

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1902 Dukeland St.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1902 Dukeland St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Christian Baur

3 (b) If veteran, name war ---
3 (c) Social Security Account No. none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Margaret Baur
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 12, 1889

8. AGE: Years 58 | Months 00 | Days 23 | If less than one day ___ hr. ___ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Plasterer

11. Industry or business U.S. Government

FATHER
12. Name John Baur
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Margaret Baur
(b) Address 1902 Dukeland St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-6-47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Md.

18 (a) Funeral director H. Howard Stang
(b) Address 3207 W. North Ave.,

19 (a) SEP 5 1947 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION 8.50

20. DATE OF DEATH September 4, 1947, at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947, to Sept 4th 1947, and that I last saw h[illegible] alive on Sept 4th 1947.

Immediate cause of death	Duration
Carcinoma of Primary Site was in G.I. Tract	about 6 Mos
Due to metastasis to Liver & Glands	
Due to cachexia	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 3033 W North Ave Date signed 9/5/47

X

G54875

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G54875 Registered No.

157E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ga. (b) County
(c) City or town Lyons. (If outside city or town limits, write RURAL and give town)
(d) Street No. Box- 149 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Linda Sue Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30-47

8. AGE: Years	Months	Days	If less than one day
	1	7 6	hr. min.

9. Birthplace Ga. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jack Moore.
13. Birthplace Ga.

MOTHER
14. Maiden Name Mary - Eason
15. Birthplace Ga

16 (a) Informant Rhonda
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof Aug 5 47 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lyons Georgia
Location

18 (a) Funeral director Williams Cook Dye
(b) Address 1217 St. Paul St.

19 SEP 5 1947 (Date rec'd by Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Sept. 5 1947, at 4:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death Congenital Heart disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Morris J Michael M. D.

Address Johns Hopkins Hosp Date signed 9-5-47

Sept 25. Affidavit by Howard J. Williams, M.D.

G54876

CWK-113411

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH · 13B

G54876 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 26-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No home address given (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Sue Yarberry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12-1917

8. AGE: Years	Months	Days	If less than one day
30	3	22	hr. min.

9. Birthplace Inglewood, Tennessee (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Roland Yarberry
13. Birthplace ? Tenn.

MOTHER
14. Maiden Name Kate Hacker
15. Birthplace ? Tenn.

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/6/47 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Balto.

18 (a) Funeral director E. J. Fanning & Son
(b) Address 1938 E. Lafayette Ave

19 SEP 5 1947 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 3 1947, at 4:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 28 1947, to Sept. 3 1947, and that I last saw her alive on Sept. 3 1947.

Immediate cause of death	Duration
Respiratory failure	3 days
Due to Spontaneous pneumothorax	4 da.
Due to Tuberculosis of lungs for advanced	5 yrs
Other Conditions Chronic Alcoholism & Malnutrition	26 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph Bowers Jr M. D.
Address Balt. City Hosp Date signed 9-3-47

X

54877

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 94a ✓ Register No. 54877

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rutland & Monument
(c) Hospital or institution: Sinai Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 508 Eastern Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Hamilton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Emma M. Wolbert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1892

8. AGE: Years	Months	Days	If less than one day
54	11	19	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Sinia Hospital

FATHER
12. Name John G.
13. Birthplace Baltimore

MOTHER
14. Maiden Name Annie Wagner
15. Birthplace Penna

16 (a) Informant Mrs. Emma M. Hamilton
(b) Address 508 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/6/47 (month) (day) (year)
(c) Cemetery or crematory Schwartzs
Location 0' Donnell St.

18 (a) Funeral director Clarence F. Hoffman
(b) Address 1639 Broadway.

19 (a) Filed 5 SEP 1947 (b) Huntington Williams, M.D.
(Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/2 1947, at 9.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/30 1947 to 9/2 1947 and that I last saw h. alive on 9/2 1947

Immediate cause of death Pulmonary Edema — Duration

Due to Cardiac Failure — 6 hrs

Due to Coronary artery thrombosis — 6 yrs

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Pul. Edema & Cardiac

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Racohnberg M.D.
Address Sinai Hosp Date signed 9/3/47

X

G54878

CWE-112628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G54878

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Month
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 Glyndon Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Wilkins

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-10-4997

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Marie ?
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) September 22-1880

8. AGE: Years	Months	Days	If less than one day
66	11	12	....hr. ....min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business Retired

FATHER
12. Name Fred Wilkins (D)
13. Birthplace Maryland

MOTHER
14. Maiden Name Emma Jane ?
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 8 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore

18 (a) Funeral director Frederick A. Ade
(b) Address 1200 W. Lombard St

19 (SEP 5 1947) Hamilton Williams, M.D.
(State filed by)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 4 1947, at 10:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 31 1947 to Sept. 4 1947, and that I last saw h im alive on Sept. 4 1947.

Immediate cause of death	Duration
Cerebral hemorrhage Rt. internal capsule.	
Due to Hypertensive Cardiovascular disease.	
Due to	
Other Conditions Bronchopneumonia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Richard T. Bamford, M.D.
Address Balt. City Hosp. Date signed 9-4-47

X

G54879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G54879

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 521 Gold St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Da Courcey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife J. Garfield

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1881

8. AGE: Years 65 | Months 9 | Days 6 | If less than one day hr. min.

9. Birthplace Westmoreland Co. Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George Wilson
13. Birthplace Virginia

MOTHER
14. Maiden Name Evelyn ??
15. Birthplace Virginia

16 (a) Informant J. Garfield DeCourcey
(b) Address 521 N. Gold St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 7, 1947 (month) (day) (year)
(c) Cemetery Arbutus Mem. Pk.
Location Balto. Co. Md.

18 (a) Funeral director Mrs. Lee A. Stafford
(b) Address 1631 Druid Hill Ave.

19 (a) SEP 6 1947 (Date received by registrar) (b) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/3 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/26 1947 to 9/3 1947 and that I last saw h-r alive on 9/3 1947.

Immediate cause of death Subarachnoid Hemorrhage

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard Hargus M.D.
Address 243 Madison Ave Date signed 9-4-47

G54880 BC# B-82278

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G54880

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) 21 min.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 230 N Carey St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1947

8. AGE: Years | Months | Days | If less than one day: hr. 21 min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Lover High
13. Birthplace Elizabeth Town, N.C.

MOTHER
14. Maiden Name Mollie Lewis
15. Birthplace Elizabeth Town, N.C.

16 (a) Informant Mollie Lewis
(b) Address 230 N. Carey St

17 (a) (Burial, cremation, removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Provident Hosp
Location 1514 Division St

18 (a) Funeral director
(b) Address

19 SEP 5 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 1926 at 6.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 26 1947 to June 26 1947 and that I last saw him alive on June 26 1947

Immediate cause of death — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H B Butler M. D.
Address Provident Hosp Date signed 9/7/47

X

G54881 BC# A87426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G54881

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. DO NOT WRITE IN SPACE RESERVED FOR BINDING.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hosp. 16th
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1826 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Gloria Faith La Grange

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1947

8. AGE: Years | Months | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Cecil La Grange
13. Birthplace Jamaica, B.W.I.

MOTHER
14. Maiden Name Blanche McKenney
15. Birthplace Washington, D.C.

16 (a) Informant U. Nash, R.N.
(b) Address Provident Hosp.

17 (a) (Burial, cremation, removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Provident Hosp.
Location 1514 Division St

18 (a) Funeral director
(b) Address

19 (a) SEP 5 1947 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11 1947, at 10 A.M. 15

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 10. 1947, to Aug. 11 1947, and that I last saw her alive on Aug. 11 1947.

Immediate cause of death	Duration
Prematurity	
Due to Atelectasis	
Bel. Congestion	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. M. Butler M. D.
Address 20 W Lanvale Date signed 9/4/47

G54882 BH
B 87426-

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G54882

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1314 Division St
(c) Hospital or institution: Provident Hospital 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1826 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Wyclif LaGrenade

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1947

8. AGE: Years | Months | Days: 2 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Cecil LaGrenade
13. Birthplace Jamaica, B.W.I.

MOTHER
14. Maiden Name Blanche McKinney
15. Birthplace Washington, D.C.

16 (a) Informant E. Nicols, Pres.
(b) Address Provident Hosp.

17 (a) (Burial) cremation or removal (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Provident Hosp.
Location 15th Division St.

18 (a) Funeral director
(b) Address

19 SEP 5 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS. 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 12 1947 at 9 15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 10 1947 to Aug. 12 1947 and that I last saw him alive on Aug. 12 1947.

Immediate cause of death	Duration
Due to Prematurity	
Due to Cong. Atelectasis	
Due to Pul. Congestion	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. D. Ballou M.D.
Address 2133 Eutaw Place Date signed Sept 5 1947

X

G54883 BCH 659917

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G54883 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 724 Lennox St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 724 Lennox St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clifford Lee (Barton) Rote

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 22-1946

8. AGE: Years	Months	Days	If less than one day
	10	12	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Barton Rote
13. Birthplace Md

MOTHER
14. Maiden Name Rosalea Sowers
15. Birthplace Md.

16 (a) Informant Barton C. Rote
(b) Address 724 Lennox St

17 (a) Burial (b) Date thereof 9/6/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Pk. Cem
Location Dorsville

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St

19 (a) Sept 6 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4th 1947, at 5 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D.
Medical Examiner

Date signed 9-5-47

G54884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G54884

157a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Green Sts
(c) Hospital or institution: University Maryland.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County York
(c) City or town York
(If outside city or town limits, write RURAL and give town)
(d) Street No. 213 N. Newberry
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Morris, Gary

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 11, 1947

8. AGE: Years | Months 6 | Days 17 | If less than one day hr. min.

9. Birthplace York, Pa.
(Town, county, and state)

10. Usual Occupation

11. Industry or business —

FATHER
12. Name Arthur E. Morris
13. Birthplace York, Pa.

MOTHER
14. Maiden Name Mae Waldt
15. Birthplace York, Pa.

16 (a) Informant Chas. H. Baumgartner
(b) Address 754 S. Queen St. York, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 8, 1947 (month) (day) (year)

(c) Cemetery or crematory Mt. Rose Cem.
Location York, Pa.

18 (a) Funeral director Wm. Cook Inc.
(b) Address 247 S. Pearl St.

19 (a) SEP 6 1947 (Date rec'd by registrar) (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5 1947, at 2:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1947 to Sept 5 1947 and that I last saw him alive on Sept 5 1947

Immediate cause of death	Duration
Hydrocephalus	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph M. Lomen M. D.
Address University Hosp. Date signed 9-5-47

C54885 1E. 33rd St

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered C54885

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 W. Lexington St.
(c) Hospital or institution: Aged Women's + Aged Mens Home 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 1/2 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W. Lexington St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Haman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5 1857

8. AGE: Years	Months	Days	If less than one day
89	10	29	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Haman
13. Birthplace Unknown

MOTHER
14. Maiden Name Ann Kuck
15. Birthplace Unknown

16 (a) Informant Aged Women's + Aged Mens Home
(b) Address 1400 W. Lexington St.

17 (a) Burial (b) Date thereof Sept. 6 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Trinity
Location O'Donnell St.

18 (a) Funeral director Wm. Cook Sons
(b) Address 1217 St. Paul St.

SEP 6 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. **DATE OF DEATH** Sept. 4, 1947, at 4:15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from August 30 1947, to Sept 4 1947, and that I last saw her alive on Sept 3 1947

Immediate cause of death	Duration
Respiratory Failure	
Due to Cerebral Hemorrhage	
Due to Arteriosclerotic Cerebro-vascular disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Haverland Edward Day M. D.
Address 4-E-33rd St Balto 18 Date signed Sept 5 1947

X

G54886

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

G54886 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 518 S. Regester St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 518 S. Regester St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Wojciech Bish (Bys)

3 (b) If veteran, name war

3 (c) Social Security Account No. 220033883

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Agata Bish
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Handyman
11. Industry or business

FATHER
12. Name Sebastian Bish
13. Birthplace Poland

MOTHER
14. Maiden Name A. Wisniewski
15. Birthplace Poland

16 (a) Informant Agata Bish
(b) Address 518 S. Regester St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 8/47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Orazewski
(b) Address 1930 Eastern Ave.

19 (a) SEP 6 1947 (Date rec'd by registrar) Washington Hill... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4 1947, at 10P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 30 19 47, to Sept. 19 47 and that I last saw h alive on Sept 3 19 1947

Immediate cause of death	Duration
Myocardial failure, acute	1 day
Due to Bronchogenic Carcinoma	1 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clarence W. McGowan M. D.
Address 681 N. Ellwood Ave. Date signed 9/5/47

V S 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54887

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 461 ✓

Registered No. G54887

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE
(c) City or town BALTIMORE (SONEREIGH)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7205 OXFORD RD. SONEREIGH
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME GUSTAV KLEMM

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.:

4. Sex: MALE | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Josephine S. KLEMM.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 5, 1897.

8. AGE: Years 50 | Months 7 | Days 0 | If less than one day ..... hr. ..... min.

9. Birthplace BALTIMORE, MD
(Town, county, and state)

10. Usual Occupation Composer of Music

11. Industry or business

FATHER
12. Name GUSTAV E. KLEMM
13. Birthplace BALTIMORE MD.

MOTHER
14. Maiden Name MARY WILDENFORST
15. Birthplace BALTIMORE, MD.

16 (a) Informant Mrs. Josephine S. Klemm
(b) Address 7205 Oxford Rd., Balto. 12, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9.8.47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 Date SEP 6 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 5 1947, at 11:47 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 19.. to Sept 5 1947. and that I last saw h.l. alive on Sept 5 1947.

Immediate cause of death: Carcinoma of Rectum & multiple metasteses. — Duration:
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel J. Bull M.D.
Address Union Memorial Hosp. Date signed 9-6-47 2:25 P.M.

X

G54888

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G54888

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1916 N. Fulton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1916 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUISE A. EULER

3 (b) If veteran, name war -
3 (c) Social Security Account No. -

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Fred J. Euler
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 25, 1885
8. AGE: Years 61 | Months 10 | Days 9 | If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation -
11. Industry or business -

FATHER
12. Name Anton Mohr
13. Birthplace Baltimore

MOTHER
14. Maiden Name Agnes Reiman
15 Birthplace Baltimore

16 (a) Informant Mr. Fred J. Euler
(b) Address 1916 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/6/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 SEP 6 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Sept 4 1947, and that I last saw her alive on Sept 3d 1947

Immediate cause of death: Pulmonary Edema with Cardiac Decompensation — Duration: 3 months

Due to: Hypertensive Arterio-Vascular disease — Duration: Years

Due to:

Other Conditions: Cerebral Accident & Paralysis — Duration: Sept 6th 46

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Augusta L. Kleiser M.D.
Address 1936 Linden Ave Date signed 9-2-47 M. D.

G54889

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

63B

Registered No. G54889

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please correct age is especially important. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LAFAYETTE AND JOHN
(c) Hospital or institution:
HOSPITAL FOR THE WOMEN OF MD.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 DAY
(e) Length of stay in Baltimore (yrs., mos., or days) 68 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1211 N. CALVERT
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country —

3 (a) FULL NAME LEOLA BYRD TRADER

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) SEPT. 28, 1878

8. AGE: Years 68 | Months 11 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace BALTIMORE MARYLAND
(Town, county, and state)

10. Usual Occupation TREASURER

11. Industry or business LINCOLN SALES CORP.

FATHER
12. Name JOHN L. TRADER
13. Birthplace SALISBURY, MD

MOTHER
14. Maiden Name ELIZABETH ELLEN LOWE
15. Birthplace SALISBURY, MD

16 (a) Informant LOLA DUNN TRADER
(b) Address 1211 N. CALVERT

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 9/8/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 SEP 6 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 4 1947, at 3 40 PM M

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT 4 1947 to SEPT 4 1947, and that I last saw her alive on SEPT 4 1947.

Immediate cause of death	Duration
MYOCARDIAL INFARCTION	
Due to ARTERIO SCLEROTIC HEART DISEASE	± 5 YRS
Due to	
Other Conditions EXOPTHALMIC GOITER	+ 1 YR.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jud B Lyon Jr. M.D.
Address Woman's Hospital Date signed Sept 4, 1947

937

G54890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G54890 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3402 Clifton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3402 Clifton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Henry Hammann

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 213-09-9968

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Pearl Frances Hammann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 22, 1886

8. AGE: Years	Months	Days	If less than one day
61	4	12	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Mgr.
11. Industry or business Hartley's Restaurant

FATHER
12. Name George Hammann
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Bocksti
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Wm. H. Hammann
(b) Address 3402 Clifton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/6/47 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 6 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 Sept. 1947, at 2:50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Hammann, Jr., M.D. Medical Examiner.
Date signed 4 Sept. 1947

G54891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. G54891

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Sq Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Co
(If outside city or town limits, write RURAL and give town)
(d) Street No. 608 N Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edna M. Foxwell

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife. Sommerfield H. Foxwell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/30/59

8. AGE: Years 87 | Months 10 | Days 4 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Wm M. [illegible]
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Callahan
15. Birthplace Maryland

16 (a) Informant Mr. Vernon L. Foxwell
(b) Address Lakewood, Ohio

17 (a) Burial (b) Date thereof 9/8/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto. Md.

19 (a) SEP 6 1947 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 Sept 1947 at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/20 1947 to 9/4 1947 and that I last saw her alive on 9/4 1947

Immediate cause of death Myocardial Failure — Duration 15 days

Due to Generalized Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Aug 21 1947

Major findings of operation: Area of gangrene of skin on lower [illegible]

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Michael R Fernando
Address Franklin Sq Hosp Date signed 9/3/47

G54892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. G54892

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1818 Aliceanna Street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 31 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1818 Aliceanna Street (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Sophie Sienkiewicz

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-07-3376

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband ~~or wife~~ Felix

6 (c) If alive, give age deceased years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Emil Pakula
13. Birthplace Poland

MOTHER
14. Maiden Name Angela ?
15. Birthplace Poland

16 (a) Informant Mary Delinski
(b) Address 1818 Aliceanna Stud

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-8-47 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Holy Rosary
Location Baltimore County Md.

18 (a) Funeral director Leo A Weber
(b) Address 725 Aliceanna Street

19 (a) SEP 6 1947 (Date rec'd by registrar) (b) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH September 5 1947, at 12:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to Sept 5 1947, and that I last saw h[illegible] alive on 9/5/47 19

Immediate cause of death Carcinoma of uterus — Duration 9 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Milton L. Solomon, M.D.
Address 129 S. Bouldy Date signed 9/5/47

G54893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G54893

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison St. & Linden Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 234 S. Madeira St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Litwinski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband ~~or wife~~ John Deceased

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878 ?

8. AGE: Years 69 70 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George Pishon
13. Birthplace Poland

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Edward Litwinski (Son)
(b) Address 938 N. Patterson Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-8-47 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A. Weber
(b) Address 705 S. Ann St.

SEP 6 1947 Huntington Williams, M.D. Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 Sept 1947, at 9:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 2 Sept 1947 to 4 Sept 1947, and that I last saw h alive on 4 Sept 1947.

Immediate cause of death Uremia — Duration 2 days

Due to Arteriosclerotic cardiovascular renal disease — Duration 20 yrs

Due to

Other Conditions Chronic pulmonary tuberculosis, active (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature G. Allan Spies

Address MD Gen. Hosp. Date signed 4 Sept 47 M.D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

G54894 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3121 Crittendon Place.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3121 Crittendon Place.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur B.Phebus.

3 (b) If veteran, name war

3 (c) Social Security Account No. 210-13-0944

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White.	Married.

6 (b) Name of husband or wife Delia G.Phebus.
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) August 7.1893

8. AGE: Years	Months	Days	If less than one day
54	-	29	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Retired Operator
11. Industry or business Baltimore Transit Co.

FATHER
12. Name James Phebus.
13. Birthplace Md.

MOTHER
14. Maiden Name Marcia Kimmel.
15. Birthplace Md.

16 (a) Informant Delia G.Phebus.
(b) Address 3121 Crittendon Place.

17 (a) Burial. (b) Date thereof Sept 9/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn.
Location Woodlawn Md.

18 (a) Funeral director Chenoweth & Donovan.
(b) Address 3615-17 Chestnut Ave.

19 (a) SEP 6 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Sept 6, 1947, at 7.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 7 1947, to Sept 6 1947, and that I last saw h. alive on Sept 5 1947.

Immediate cause of death — Duration

Due to Carcinoma of rt lung and metastasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard Gallenstein M. D.
Address 848 W 3 Cafe Date signed 9-6-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G54895

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 721 W.36th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 721 W.36th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lavina Baker.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed.

6 (b) Name of husband or wife James M. Baker.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31,1861

8. AGE: Years	Months	Days	If less than one day
86	5	4	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation None.
11. Industry or business

FATHER
12. Name William Gorsuch.
13. Birthplace Md.

MOTHER
14. Maiden Name Mary J.Poole.
15. Birthplace Md.

16 (a) Informant Mrs Ada Peregoy.
(b) Address 721 W.36th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 7,1947 (month) (day) (year)
(c) Cemetery or crematory Mt Pleasant.
Location Gamber, Md.

18 (a) Funeral director Chenoweth & Donovan.
(b) Address 3615-17 Chestnut Ave.

19 SEP 6 1947 (b) Huntington Williams, M.D. (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 4,1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 7 1947 to 9/4 1947 and that I last saw h[illegible] alive on 9/4 1947.

Immediate cause of death	Duration
Cerebral thrombosis	24 hrs.
Due to arteriosclerosis	
Due to	
Other Conditions epithelioma face	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.
Address 2020 N. Charles St. Date signed 9/6/47

935

G54896

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 13B

G54896 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3712 Falls Road.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

13 T

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3712 Falls Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Wade M. Headley.

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 216 10 7481
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Margaret Headley
6 (c) If alive, give age 39 years
7. Birth date of deceased (mo., day, yr.) April 22, 1903
8. AGE: Years 44 | Months 4 | Days 11 | If less than one day ____ hr. ____ min.
9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Fisher Body Co

FATHER
12. Name Ezekiel Headley.
13. Birthplace Va.

MOTHER
14. Maiden Name Effie Smith.
15. Birthplace Va.

16 (a) Informant Margaret Headley.
(b) Address 3712 Falls Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 6/47 (month) (day) (year)
(c) Cemetery or crematory Moreland Park.
Location Taylor Ave.

18 (a) Funeral director Chenoweth & Donovan.
(b) Address 3615 17 Chestnut Ave.

19 SEP 6 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Address 3715 Falls Rd Date signed 9-4-47

VS 150

MEDICAL CERTIFICATION P.

20. DATE OF DEATH Sept 3, 1947, at 9.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 6 1947 to Sept 3 1947, and that I last saw h.n.k. alive on Sept 3 1947

	Duration
Immediate cause of death: Pulmonary Hemorrage	Sept 3
Due to: Bilateral Tuberculosis	?
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Laurence J. Shimanek M. D.

SHIMANEK X

G54897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157 E

Registered No. G54897

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 428 N. Carrollton Ave.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME (1) (4) (2) (3)
Aldrema Wilkins (Brooks Fallin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	married

6 (b) Name of husband or wife Henry.
6 (c) If alive, give age 19. years

7. Birth date of deceased (mo., day, yr.) 4-21-27.

8. AGE: Years	Months	Days	If less than one day
20	4	13	.....hr. .....min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation House Wife.
11. Industry or business

FATHER
12. Name Oscar Fallin
13. Birthplace Va.

MOTHER
14. Maiden Name Viola Tomlin
15. Birthplace Va.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 9 | 8 | 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Pressman St

19 SEP 6 1947 Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4 1947, at 7.15 A/M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug-31 1947, to Sept-4 1947, and that I last saw h[illegible] alive on Sept 4 1947.

Immediate cause of death Renal failure — Duration 8 months

Due to Chronic glomerulonephritis

Due to.....

Other Conditions Congenital heart disease & cardiac failure ; ?subacute bact. endocarditis

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature David Hrob M. D.

Address J N H Date signed 4 Sept 47

13, B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

654898 B# 83403 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 159 ✓ Registered No. 654898

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Providence Hospe
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 1504 Mountmore ct
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1574 Dimson St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby (albert) Strothers
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/30/47

8. AGE: Years | Months 2, | Days 23 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Haywood Strother
13. Birthplace D.C.

MOTHER
14. Maiden Name Ella Winston
15. Birthplace Va

16 (a) Informant Ella Strothers
(b) Address Va

17 (a) Burial (b) Date thereof 9/6/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Pressalmans

19 (a) SEP 6 1947 (b) Huntington Williamsport, Md
(Date received by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 1947, at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 30 1947, to Aug. 23 1947 and that I last saw h[illegible] alive on 8/23 1947.

Immediate cause of death Asphyxiation — Duration 2 mo

Due to Paralysis of Glottis

Due to

Other Conditions Bronchitis

(Include pregnancy within 3 months of death)

Date of operation /

Major findings of operation: /

of autopsy: /

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank M. Cullen

Address 1543 Penna Ave Date signed 9/6/47

105

G54899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G54899

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A
(b) Street address 2028 E. Lombard St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs 2 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2028 E. Lombard St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country Naturalized American

3 (a) FULL NAME ~~John Hatzuk~~ JOHN P. HANDZIUK

3 (b) If veteran, name war —

3 (c) Social Security Account No. 368-07-8286

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife MARIA SPARY

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years	Months	Days	If less than one day
58	—	—	____ hr. ____ min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Clergyman

11. Industry or business

FATHER
12. Name Paul Handziuk
13. Birthplace Russia

MOTHER
14. Maiden Name MARIA (?)
15. Birthplace Russia

16 (a) Informant Olga Zoyrunich (Daughter)
(b) Address 2028 E. Lombard St.

17 (a) Burial (b) Date thereof Sept. 9, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Nicholas
Location Flint, Michigan

18 (a) Funeral director Walter Burke Bradley
(b) Address 1222 W. North Ave.

19 (a) SEP 6 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/4 1947 at 7:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? ____ While at work? ____
(d) Means of injury

23. Signature C. J. Tubbinshe M.D.
Medical Examiner.
Date signed 9/7/47

X

G54900 URLWIN O. MICHAELS

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G54900

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & 33rd Sts.

(c) Hospital or institution Union Memorial Hospital Baltimore

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3days

(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 100 W. University Parkway (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** Mr. Urlwin O. Michaels

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Mrs. Urlwin O Michaels

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1875

8. AGE: Years 71 | Months 9 | Days 13 | If less than one day ..... hr. ..... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Insurance Broker

11. Industry or business

FATHER 12. Name Rev. R. E. Michaels

FATHER 13. Birthplace Virginia

MOTHER 14. Maiden Name Lucy Handy

MOTHER 15. Birthplace Virginia

16 (a) Informant Mrs. Urlwin Michaels

(b) Address 100 West Univ. Park.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/6/47 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Hollywood Location Richmond, Va.

18 (a) Funeral director W. W. Mears and Son

(b) Address 805 N. Calvert St.

19 SEP 6 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5th 1947 at 2:19 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2, 1947, to Sept 5 1947 and that I last saw h.i. alive on Sept. 5 1947.

Immediate cause of death	Duration
Cardiovascular Collapse	
Due to Cerebral Hemorrhage	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Norman R. Freeman Jr. M.D.

Address Union Memorial Hosp Date signed Sept 5 '47

G54901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

111B

G54901 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1031 N. Caroline st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLAYTON ROSS, JR.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1947

8. AGE: Years	Months	Days	If less than one day
	1		hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Clayton Ross
13. Birthplace Va

MOTHER 14. Maiden Name Stella Mae Borie
15. Birthplace S.C.

16 (a) Informant Mary Ellen Lowe
(b) Address 1031 N. Caroline St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/6/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location G.G. County

18 (a) Funeral director Mrs. Lott G. Elliott, Dyer
(b) Address 1129 N. Caroline St

19 (a) Sept 6 1947 Huntington Williams MD
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-3-1947, at 10:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute pulmonary edema

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature G. Morgan G. Merrill M.D.
Medical Examiner.
Date signed 9/3/47

VS 151

54902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

G54902 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3901 Fleetwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3901 Fleetwood Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Annie L. Huster

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife: James E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1864

8. AGE: Years 83 | Months 7 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Joseph Rush
13. Birthplace Germany

MOTHER
14. Maiden Name Sophia Gosriel
15. Birthplace France

16 (a) Informant Anna Rush
(b) Address 3901 Fleetwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location old Frederick Rd.

18 (a) Funeral director M. W. E. Dippel's Sons
(b) Address 7110 Belair Rd.

19 (a) REC'D 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5 1947, at 8 45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1947 to Sept 4 1947 and that I last saw h e alive on 9/4 1947.

Immediate cause of death	Duration
Carcinoma of ovary	4 mos.
Due to	
Due to	
Other Conditions Carcinoma Myocarditis (Include pregnancy within 3 months of death)	24 hrs.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. E. Fleetwood Benson M. D.
Address 1 W. Overlea Ave. Date signed 9/5/47

X

G54903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 581

Registered No. G54903

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 505 Walker Ave (If rural give location)
(e) Citizen of foreign country? U.S. (Yes or No)
If yes, name country

3 (a) FULL NAME Mildred Boggan

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Thomas W. Boggan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/4/14

8. AGE: Years	Months	Days	If less than one day
33	1	22	hr. min.

9. Birthplace Baltimore, MD (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frederick Stockrun
13. Birthplace Maryland

MOTHER
14. Maiden Name Elsa Otto
15. Birthplace Germany

16 (a) Informant Thomas Boggan
(b) Address 505 Walker Ave-City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 8 '47 (month) (day) (year)
(c) Cemetery or crematory Schwartz Farm
Location Reisterstown Rd.

18 (a) Funeral director John F. Mahan
(b) Address 3000 E. Balto. St.

SEP 6 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5 1947, at 4:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-30 1947 to 9-5 1947, and that I last saw her alive on 9-4 1947

Immediate cause of death	Duration
Uremia	
Fibrosis.	
Due to Acute Pulmonary Edema	
Due to Rheumatic Heart Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. McShane M. D.
Address Date signed 9-5-47

Hosp X McShane

G54904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G54904

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 824 Eastern Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 76 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 824 Eastern Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Leo Bacigalupa

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	212-14-2865

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of ~~husband~~ or wife late Louise
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24 1870

8. AGE: Years	Months	Days	If less than one day
77	1	12	hr. min.

9. Birthplace Italy
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Andrew Bacigalupa
13. Birthplace Italy

MOTHER
14. Maiden Name Catherine Costa
15. Birthplace Italy

16 (a) Informant Crescentia Azzaro (Daughter)
(b) Address 824 Eastern Ave

17 (a) Burial (b) Date thereof Sept. 8 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or Crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 SEP 6 1947 (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 6 1947, at 11 A M

21. I certify that death occurred on the date above stated, that I attended deceased from July 4 1946 to Sept 6 1947 and that I last saw h~~e~~r alive on Sept 6 1947

Immediate cause of death Cardiac Insufficiency — Duration 1 Yrs
Due to Nephritis
Due to Senility
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jos. L. Valentine M.D.
Address 1732 Bryden Rd
(Date signed) 9-7-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C54905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

Registered No. C54905

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec.
(e) Length of stay in Baltimore (yrs., mos., or days) 30yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 204 Myrtle Avenue
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Hannah Butler

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
No	None	Female	Colored	Separated

6 (b) Name of husband or wife James
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/12/1888

8. AGE: Years	Months	Days	If less than one day
59	4	20	hr. min.

9. Birthplace Chestertown, Md. (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business

FATHER
12. Name James Daniels
13. Birthplace Chestertown, Md.

MOTHER
14. Maiden Name Minnie Goldsboro
15. Birthplace Chestertown, Md.

16 (a) Informant Sadie Melton (Sister)
(b) Address 1228 Rankin Pl.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem(l. Pk.
Location Balto. County, Md.

18 (a) Funeral director Charles C. Cooper
(b) Address 510-12 N. Carrollton Ave

SEP 6 1947 (b).....
(Date rec'd by registrar)

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH September 4, 1947 at 12 M

21. I certify that I took charge of the remains described above, held an Inspection, thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio-Vascular Disease
Due to.....
Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 9-4-47

G54906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

G54906 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Saint St.
(c) Hospital or institution: University Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 18yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 542 N. Carey St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lewis Gaines

3 (b) If veteran, name war: W.W.#1

3 (c) Social Security Account No. 216-09-1791

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/15/~~1896~~ 1894

8. AGE: Years ~~53~~ 53 | Months 4 | Days 18 | If less than one day ..... hr. ..... min.

9. Birthplace Lancaster Co. Va.
(Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business

FATHER
12. Name Iverson Gaines
13. Birthplace Va.

MOTHER
14. Maiden Name Eliza Gaines
15. Birthplace Va.

16 (a) Informant James W. Gaines (Bro.).
(b) Address Lively, Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/47 (month) (day) (year)
(c) Cemetery or crematory Bulah Cemetery
Location Lively, Va.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave

19 (a) SEP 6 1947 (Date received by registrar) (b) Huntington Nitkin, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 3 1947, at 8 00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1947, to Sept 3 1947, and that I last saw h[illegible] alive on Sept 3 1947.

	Duration
Immediate cause of death: Circulatory & Respiratory Collapse	
Due to: Examination due	
Due to: Ulcerated Carcinoma? Stomach & ulceration into	
Other Conditions: Liver & Esophagus. Metastasis to liver & adjacent lymph nodes	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sidney K. Patch

Address Univ. Hosp. Date signed 9/2/47 M.D.

X

G54907 — BALTIMORE CITY HEALTH DEPARTMENT — G54907 Registered No.

CERTIFICATE OF DEATH 927

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1 W. Franklin street
(c) Hospital or institution: 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 59 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. The Rochambeau Apts. 1 West Franklin street (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME AGNES CHRISTINA BOONE

3 (b) If veteran, name war	3 (c) Social Security Account No.
---	---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	Widow

6 (b) Name of husband or wife Matthew C. Boone
6 (c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) Nov. 27 1869

8. AGE: Years	Months	Days	If less than one day
77	9	7	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace Ireland

MOTHER
14. Maiden Name Annie Adams
15. Birthplace Ireland

16 (a) Informant Miss Daisy Boone
(b) Address 1 West Franklin street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location

18 (a) Funeral director Chas J. Evans & Son Inc
(b) Address 112 W. Mt. Royal Ave

19 SEP 7 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4 1947, at 1.20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-2-1947 to 9-3-1947, and that I last saw h.. alive on 9-3-1947.

Immediate cause of death	Duration
Cerebral Thrombosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Harrison M. D.
Address 132 W. Lanvale Date signed 9/6/47

G54908

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G54908 Registered No. 10a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts
(c) Hospital or institution: University 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1634 Gwynns Falls Parkway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Seamon Nathaniel Fine

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married~~, ~~widowed~~, or ~~divorced~~.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 25, 1895

8. AGE: Years	Months	Days	If less than one day
52	7	11	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Merchant

11. Industry or business

FATHER
12. Name Morris L Fine
13. Birthplace Russian

MOTHER
14. Maiden Name Bertha R. Blumm
15. Birthplace Russia

16 (a) Informant Morris L. Fine
(b) Address 1634 Gwynn Falls Parkway

17 (a) Burial (b) Date thereof 9 7 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sinai Emunah Cemetry
Location Washington Blvd

18 (a) Funeral director H. Levinson & Bro
(b) Address 1124-26 W. North ave

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

SDS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5 1947, at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1947 to Sept 5 1947, and that I last saw h alive on Sept 5 1947

Immediate cause of death	Duration
Convulsions due to Brain abscess	
Due to Lung abscess	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. C. Durvall Jr. M. D.

Address Univ. Hosp. Date signed Sept 6

X

G54909

BALTIMORE CITY HEALTH DEPARTMENT ✓ G54909

CERTIFICATE OF DEATH 94a

Registered No.

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1730 Warwick Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ARTHUR A. H. Morgan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Sophie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 55 | Months 8 | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Bernard
13. Birthplace Russia

MOTHER
14. Maiden Name Pearl
15. Birthplace Russia

16 (a) Informant Sophie Morgan
(b) Address 1760 Warwick Ave

17 (a) Burial (b) Date thereof 9-7-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory United Hebrew
Location Washington Boulevard

18 (a) Funeral director D. K. Lewis Inc
(b) Address 2160 Eutaw Place

19 (a) 1947 (b) Clayton Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/6 1947, at 10:40 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 9/6/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a G54910

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State ~~Md~~ (b) County
(c) City or town ~~Balto~~ Wash. D.C. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3729 McKinley St N.W. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME STANLEY HIMMELSTEIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APR. 5, 1925

8. AGE: Years 22 | Months 4 | Days 29 | If less than one day ____hr. ____min.

9. Birthplace BALTO. MD (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name SAMUEL HIMMELSTEIN
13. Birthplace RUSSIA

MOTHER
14. Maiden Name BESSIE
15. Birthplace BALTO. MD

16 (a) Informant FATHER
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-7-47 (month) (day) (year)
(c) Cemetery or crematory MT CARMEL
Location OLD GERMAN HILL RD

18 (a) Funeral director JACK LEWIS INC
(b) Address 2400 EUTAW PLACE

19 (a) (Date rec'd by regis.) (b) Registrar

SEP 7 VS 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 1947 at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/2/1947 to 9/4/1947, and that I last saw him alive on 9/4/1947.

Immediate cause of death: Pneumothorax, spontaneous

Due to: Cerebral Hemorrhage

Due to: Acute Pericarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irwin Cohen M. D.
Address Sinai Hosp. Date signed 9/4/47

X

G54911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G54911
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1040 Edmondson Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1040 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Jones.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Johnnie Jones

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15 1869

8. AGE: Years 78 | Months 6 | Days 19 | If less than one day hr. min.

9. Birthplace Balto. Co. Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Henry Jones,
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Mary Jane ?
15. Birthplace Balto. Co. Md.

16 (a) Informant Samuel G. Jones
(b) Address 307 N. Central Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 7th 1927 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. Co. Md.

18 (a) Funeral director Belt Smith & Wright
(b) Address 721 Edgewood St

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 7 1927 Huntington Hillegeist M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4 1927, at 5:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 29 1927, to Sept. 4 1927, and that I last saw him alive on Sept. 1 1927.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Interstitial Nephritis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature

Address 556 N. Fremont Ave Date sig

G54912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓83a

G54912
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2504 W. Lanvale St.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2504 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Benson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1875

8. AGE: Years	Months	Days	If less than one day
72	2	25	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William D. Benson
13. Birthplace Somerset County, Md.

MOTHER
14. Maiden Name Hannah Jane Kelly
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Emma G. Benson
(b) Address 2504 W. Lanvale St.

17 (a) Burial (b) Date thereof 9/8/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~crematory~~ Loudon Park
Location 3801 Frederick Ave., Baltimore

18 (a) Funeral director John C. Whitehead & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) SEP 7 1947 (b) Emmitt for Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 5 1947, at 3 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1942 to 9/5 1947 and that I last saw her alive on 9/5 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	10 days
Due to Uremia - Sclerosis	8 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Homer L. Dodd M. D.
Address 2108 St. Paul St. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G54913 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert St.
(c) Hospital or institution:
Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days
(e) Length of stay in Baltimore (yrs., mos., or days) 77yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Baltimore
(c) City or town RURAL-CATONSVILLE, MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 106 Newbury Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Louis William Freund

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mrs. Laura Freund
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/20/1870

8. AGE: Years	Months	Days	If less than one day
77	8	16	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Merchant
11. Industry or business

FATHER
12. Name Jacob Freund
13. Birthplace Bavaria

MOTHER
14. Maiden Name Magdelena
15. Birthplace Germany

16 (a) Informant Mrs. Laura Jane Freund
(b) Address 106 Newbury Ave, Catons, Md.

17 (a) Burial (b) Date thereof 9-8-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore

18 (a) Funeral director George A. Farley
(b) Address Fulton, Near Fayette St.

19 (a) (b)
(Date rec'd) (Registrar) Registrar

SEP 7 1947
VS 150
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5 1947, at 7:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/3 1947, to 9/5 1947, and that I last saw h[illegible] alive on 9/4 1947.

Immediate cause of death Coronary occlusion.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy: Coronary occlusion

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address Union Memorial Hosp. Examined

X 9/5/47

G54914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G54914

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1907 Homewood Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 ?
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1907 Homewood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rachael ~~Rachael~~ Barry ~~Erline~~ Erline.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years 59 | Months | Days | If less than one day hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation At-Home.

11. Industry or business

FATHER
12. Name Samuel H. Barry
13. Birthplace Balto.

MOTHER
14. Maiden Name Blanche Le Brun Barry
15. Birthplace France.

16 (a) Informant Mr. Wm. A. Erline
(b) Address 1907 Homewood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-8-47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location City

18 (a) Funeral director Wiedefeld & Son
(b) Address Greenmount Ave & 22nd

19 (a) 1947 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4th 1947, at 7.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 to Sept 4 1947.
and that I last saw h. or alive on Sept 4, 1947.

Immediate cause of death: Cachexia and exhaustion

Due to Carcinoma of uterus beginning in cervix — Duration: 2 yrs.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. H. Hayward M. D.
Address 115 E Eager St Date signed 9/5-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 E

G54915 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 828 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jane E. McDermitt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-20-89

8. AGE: Years	Months	Days	If less than one day
57	10	20	hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Registrar
11. Industry or business

FATHER 12. Name Hugh McDermitt
13. Birthplace Pa.

MOTHER 14. Maiden Name Mary Dale
15. Birthplace Pa.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept. 7, 1947 (month) (day) (year)
(c) Cemetery or crematory St. Ignatius
Location Adams County, Penna.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Ry. aves.

19 (a) SEP 9 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6th 1947, at 7.35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 23 1947, to Sept 6 1947, and that I last saw h er alive on Sept. 6 1947.

Immediate cause of death	Duration
Peritonitis	4 d
Due to Operation for	
Due to Carcinoma of Sigmoid inoperable	9 Mo.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 9-2-47
Major findings of operation: Carcinoma of sigmoid,
of autopsy: " "

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. B. Morrow M. D.
Address JHH Date signed 9-6-47

C54916 Benjamin Miller 2050 Hollins Ave.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. C54916

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1702 Hollins St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 Hollins St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William F. Keirle

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-03-6148

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Minnie Keirle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 17, 1870

8. AGE: Years	Months	Days	If less than one day
70	6	17	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Guard
11. Industry or business Pinkerton Detective

FATHER
12. Name William T. Keirle
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Annie Connell
15. Birthplace Washington, D.C.

16 (a) Informant Mrs. Jennie Bradmond
(b) Address 1702 Hollins St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 8, 1947 (month) (day) (year)
(c) Cemetery or crematory London Park.
Location Frederick Rd.

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St Paul St.

19 SEP 8 1947 Huntington Williams, M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/4 19 47 at 8:04 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/1 1946, to 9/4 47.
and that I last saw him alive on 9/4/47, 19

Immediate cause of death Carcinoma of sigmoid — Duration 2 yr

Due to

Due to

Other Conditions Bronchopneumonia — 1 day

(Include pregnancy within 3 months of death)
Date of operation Aug. 2, 1946
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M.D.
Address 2050 Wilkens Ave Date signed 9/8/47

VS 150

ar

G54917

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V51B

G54917
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5516 Hill Top Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward E. Knauff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Mary Knauff

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 30, 1868

8. AGE: Years 79 | Months 0 | Days 6 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired Paper Hanger

11. Industry or business

FATHER
12. Name William G. Knauff
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Longhorn
15. Birthplace Maryland

16 (a) Informant Milton W. Knauff
(b) Address 1100 Overbrook Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 9 1947 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave.

18 (a) Funeral director Wm. Cook Sons
(b) Address 1217 St. Paul St.

19 (a) SEP 8 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 Sept 1947, at 10:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/2/ 1947 to 9/6 1947 and that I last saw h alive on 9/6 1947.

Immediate cause of death	Duration
Carcinoma of Prostate	1 yr
Due to Lymphatic Leukemia	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 7/28/47

Major findings of operation: Adenocarcinoma of Prostate

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. A. Cassano M. D.
Address Md Gen'l Hosp Date signed 9/6/47

C54918 VL - 104470

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C54918

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 530 Orkney Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William B. Wood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Katherine (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 27, 1873

8. AGE: Years	Months	Days	If less than one day
74	6	19	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation C. P. A.
11. Industry or business

FATHER
12. Name William B. Wood
13. Birthplace Va.

MOTHER
14. Maiden Name Isabelle Hall
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern

17 (a) Burial (b) Date thereof 9/9/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto.

18 (a) Funeral director Wm Cook Bro.
(b) Address 1317 St Paul St

19 (a) SEP 8 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6 1947, at 2am M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-12 1946, to Sept. 6 1947, and that I last saw him alive on Sept 6 1947.

Immediate cause of death: bronchopneumonia, bilateral — Duration 7 Days

Due to: ?

Due to: urinary infection, arteriosclerotic heart disease — Duration 28 & 2 years.

Other:

(Include pregnancy within 3 months of death)
Date of operation [redacted] 8/9/47
Major findings of operation: ischiorectal abscess
of autopsy:

22. If death was due to external causes fill in the following: none
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Merrill F. Nelson
Address BCH Date signed 9/7/47

PHYSICIAN
Underline the cause to which death should be charged statistically.

G54919

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G54919

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: City Jail Infirmary
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 337 E. North Ave.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Claude Fields

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: W.

6 (b) Name of husband or wife Mae M.

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Apr. 15. 1886

8. AGE: Years: 61 | Months: 4 | Days: 13 | If less than one day: ..... hr. ..... min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant John H. Fields
(b) Address 728 E. 20th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/47 (month) (day) (year)
(c) Cemetery or crematory Woodland Pk Cem
Location Parkville, Balto Co.

18 (a) Funeral director Wm Cook Sons.
(b) Address 1217 E Pratt St.

19 (a) SEP 8 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH September 5 1947, at 8:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH Coronary artery disease

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Earl L. Royer M.D.
Medical Examiner

Date signed 9-6-47

G54920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G54920 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~2500 Freeway~~
(c) Hospital or institution: Bon Secours Hosp. 2701 H
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month
(e) Length of stay in Baltimore (yrs., mos., or days) 67 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2500 Freeway 4221
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. George Whiting

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Suzanne

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11 (6) 79

8. AGE: Years	Months	Days	If less than one day
67	10	4	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation executive

11. Industry or business

FATHER
12. Name Clarence Whiting
13. Birthplace Va.

MOTHER
14. Maiden Name Menina Armistead
15. Birthplace Va.

16 (a) Informant Dr Whiting
(b) Address Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St

19 (a) SEP 8 1947 (Date rec'd by registrar) (b) Huntington for Milligan Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7 (6) 1947, at 2:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 2 1947, to Sept 7 1947, and that I last saw h.. alive on Sept (6) 1947.

Immediate cause of death	Duration
coronary heart disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lewis B Whiting

Address 319 Mechanics Date signed 9-7-47

X

G54921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G54921

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County a. a.
(c) City or town Gambrills
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy (B) Staples

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-27-47

8. AGE: Years	Months	Days	If less than one day
		0 9	20 hrs. min.

9. Birthplace md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William E. Staples
13. Birthplace Va.

MOTHER
14. Maiden Name Anne Christman
15. Birthplace S. Dakota

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Sept 8 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Memorial
Location Millersville Md

18 (a) Funeral director H. L. Hopkins & Son
(b) Address Annapolis Md.

19 (a) SEP 8 1947 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6 1947, at 8 95 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 25 1947, to Sept 6 1947, and that I last saw h[illegible] alive on Sept 6 1947.

Immediate cause of death	Duration
CARDIO-RESPIRATORY FAILURE	
Due to PREMATURITY	
Due to	
Other Conditions ? INTESTINAL OBSTRUCTION -	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William A. Spencer
Address Johns Hopkins Hosp Date signed 9/7/47
Herbert Fane

VS 150

159

654922

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No. 654922

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: W. B. C. H. 7 D
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2731 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Henry W. Kronenberg.
3 (b) If veteran, name war —
3 (c) Social Security Account No. 219-01-0943

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Mary D
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) April 14, 1885

8. AGE: Years	Months	Days	If less than one day
62	4	23	____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Gus Kronenberg
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Boettee
15. Birthplace Germany

16 (a) Informant Mary D. Kronenberg
(b) Address 2731 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/10/47 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 (a) SEP 8 1947 (b) Date rec'd by registrar (c) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/7 1947, at 4:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/22 1947, to 9/7 1947 and that I last saw h[im] alive on 9/7/ 1947.

Immediate cause of death	coronary failure	Duration
Due to	myocardial insufficiency	
Due to	post operative removal Ca of esophagus	
Other Conditions		

(Include pregnancy within 3 months of death)
Date of operation 9/5/47
Major findings of operation: Ca. of esophagus
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. G. Williams M.D.
Address W. B. C. H. Date signed 9/7/47

G54923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G54923 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. General Hospital 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1202 Jenkins alley (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Elizabeth Carroll (Duvall)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7 1865

8. AGE: Years	Months	Days	If less than one day
82	3	28	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name ?
13. Birthplace Maryland

MOTHER
14. Maiden Name Dixon
15. Birthplace Maryland

16 (a) Informant Mary Duvall Granddaughter
(b) Address 1636 Ellsworth St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-8-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 1917 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 4 1947, at 3:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to last death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl H. Poyer M.D. Medical Examiner
Date signed 9-5-47

X

G54924

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓132

Registered No. G54924

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3412 E Fairmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3412 Fairmount (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard E Rodrick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Marie Rodrick

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28 1911

8. AGE: Years	Months	Days	If less than one day
36	3	8	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Cheuffuer
11. Industry or business

FATHER
12. Name Charles Rodrick
13. Birthplace Balto

MOTHER
14. Maiden Name Mary Fuss
15. Birthplace Md

16 (a) Informant Mrs Charles Rodrick
(b) Address 3412 Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 9 1947 (month) (day) (year)
(c) Cemetery or crematory Schwartz
Location O'Donnel St

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St

SEP 8 1947 (Date rec'd by registrar) Huntington Williams, M.D.

V S-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6 1947, at 9 15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1941 to Sept 6 1947, and that I last saw h alive on Sept 5 1947

Immediate cause of death	Duration
Pulmonary Tuberculosis	1-1-41
Tubercular Meningitis	any 30/47
Due to	
Due to	
Other Conditions None.	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature F. A. Schwenck M. D.
Address 842 S. Ea[illegible] Ave Date signed 9-8-47

G54925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G54925

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs ½
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 11 Elm Ave Overlea (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anton Rosmeisl (ANTON ROSMEISL)

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2, 1892

8. AGE: Years	Months	Days	If less than one day
55	4	3	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Laborer, ret. 10yrs
11. Industry or business Ship Yard

FATHER
12. Name Anton Rossmeisl
13. Birthplace Austria

MOTHER
14. Maiden Name Pauline Berg
15. Birthplace Germany

16 (a) Informant Miss Martha Rossmeisl -sister
(b) Address 11 E. Elm Ave. - 5

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 9/8/47 (month) (day) (year)
(c) Cemetery or crematory GREENMOUNT CREMATORIUM
Location BALTIMORE, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

19 (a) SEP 8 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5th 1947, at 9 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Alcoholism

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl H. Kyler M.D. Medical Examiner.
Date signed 9-6-47

Roy

G54926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G54926

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Dorset
(c) City or town Ellicott City (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roy Lee De Lawder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1893

8. AGE: Years	Months	Days	If less than one day
53 54	9		hr. min.

9. Birthplace W. Va. (Town, county, and state)

10. Usual Occupation Saw Mill Hand

11. Industry or business

FATHER
12. Name Edward A. De Lawder
13. Birthplace W. Va

MOTHER
14. Maiden Name Lydia A. Strawgerman
15. Birthplace W. Va.

16 (a) Informant Floyd De Lawder
(b) Address Ellicott City Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-11-47 (month) (day) (year)
(c) Cemetery or crematory Family Plot
Location Mathias W Va

18 (a) Funeral director J C Higinbothom
(b) Address Ellicott City Md

19 (a) D.C.D. 9 1947 at Huntington Williams, M.D. (Date received by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-7-1947, at 4 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull Ruptured Kidney

Due to

Other Conditions Fractures of Ribs + Liver

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-7-47 at 1 A. M. (Date)
(b) Where did injury occur? Dorsey Rd + Washington Blvd
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Hit + Run

23. Signature [signature] M.D. Medical Examiner.
Date signed 9-8-47

C54927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. C54927

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3404 Callaway Ave.
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3404 Callaway Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME J. NORRIS McFARLAND

3 (b) If veteran, name war: none
3 (c) Social Security Account No.:

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widower

6 (b) Name of husband or wife: Jerusha G. McFarland
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8, 1883

8. AGE: Years 64 | Months 6 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation
11. Industry or business Work - Merchant

FATHER
12. Name William A. McFarland
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary M. Sowers
15. Birthplace Baltimore

16 (a) Informant Mr. Rowland Y. Mills
(b) Address 4 Chaucary Square

17 (a) Burial (b) Date thereof 9/8/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

SEP 8 1947

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5 1947, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 5 1943 to Sept 5 1947, and that I last saw him alive on Sept 3 1947.

Immediate cause of death	Duration
Myocarditis anemia pedema	
Due to	
Due to	
Other Conditions Edema hypotension	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Jno A Lankester M. D.
Address 12 Eager St Date signed Sept 6/47

X

G54928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G54928 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1002 Seaden hall St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1002 Seaden hall st (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Myrtle Banks

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: ---

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug-1-1913

8. AGE: Years 34 | Months 1 | Days 4 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Canning Factory

11. Industry or business Packer

FATHER
12. Name Samuel Banks
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Carrie W Pate
15. Birthplace A. A. Co. Md.

16 (a) Informant Carrie Johnson
(b) Address 1002 Seaden hall

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co. Md

18 (a) Funeral director Samuel L Brown
(b) Address 108 N Monkgomery St

19 (a) SEP 8 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/5 1947 8P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1946 to 9/5 1947 and that I last saw her alive on Sept 1 1947.

Immediate cause of death Chronic Endocarditis — Duration 10 Mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David Brandeis M.D.
Address 1111 N Eutaw Date signed 9/6/47 M. D.

VS 150

G54929

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G54929

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 51st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 64 days
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 1308 W. Mulberry St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: Grover Cleveland Ray

3 (b) If veteran, name war: WW I

3 (c) Social Security Account No.: 212-16-9696

4. Sex: M

5. Color or race: col

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Virgia White Ray

6 (c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): March 9, 1895

8. AGE: Years: 52 | Months: 5 | Days: 27 | If less than one day: ____ hr. ____ min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business:

FATHER
12. Name: Jim Ray
13. Birthplace: Balto, Md.

MOTHER
14. Maiden Name: Rose ?
15. Birthplace: Baltimore, Md.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 9, 1947 (month) (day) (year)
(c) Cemetery or crematory: Balto. National Cem.
Location: Baltimore Md.

18 (a) Funeral director: Chas. S. Wilson
(b) Address: 1000 Broadway

19 (a) SEP 8 1947 (Date rec'd by registrar) (b) Huntington Williamson M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 5 19 47 at 8:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1947, to Sept. 5 1947, and that I last saw h. im alive on Sept. 5 19 47.

Immediate cause of death: Adenocarcinoma of stomach with widespread metastases — Duration: UNKNOWN

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address: Clinical Director Date signed: 9/5/47

X

G54930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G54930

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 804 George st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY D. JACKSON GAUSS

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION A.

20. DATE OF DEATH 9-5- 1947, at 7 M

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	M

6 (b) Name of husband or wife Robert Jackson Gauss
6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) 1914

8. AGE: Years	Months	Days	If less than one day
33			hr. min.

9. Birthplace South Carolina (Town, county, and state)
10. Usual Occupation Canning House Work
11. Industry or business

FATHER
12. Name Bezen Johnson
13. Birthplace South Carolina

MOTHER
14. Maiden Name unknown
15. Birthplace " "

16 (a) Informant Robert Jackson Gauss
(b) Address 804 George St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/47 (month) (day) (year)
(c) Cemetery or crematory New Town Cem.
Location Lawrenceburg N.C.
18 (a) Funeral director Leroy D Wilson
(b) Address 1010 Boundary ave
19 (a) SEP 8 1947 (Date rec'd by registrar) (b) Huntington Williamsport Md

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Artery disease
Obesity
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 9/5/47

VS 151

G54931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 170 c

Registered No. G54931

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days): Dea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5802 Belgrove Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Melvin Powell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/2/1930

8. AGE: Years	Months	Days	If less than one day
16	8	23	hr. min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER
12. Name Clyde Powell
13. Birthplace North Carolina

MOTHER
14. Maiden Name Annie Terry
15. Birthplace North Carolina

16 (a) Informant Annie Terry
(b) Address 5802 Belgrove Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 9, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md

18 (a) Funeral director Elroy D. Wilson
(b) Address 1000 Brantley ave

19 (a) SEP 8 1947 (Date rec'd by registrar) (b) Permit for Burial Issued

MEDICAL CERTIFICATION

20. DATE OF DEATH September 5 1947, at 5 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull
Laceration of Brain
Due to Intracranial Hemorrhage

Other Conditions Ruptured liver & kidney.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-5-47 at 4:15 P M.
(b) Where did injury occur? Patapsco Ave. & Potee St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? yes
(d) Means of injury Fell from moving truck

23. Signature Howard J. Meeker M.D.
Medical Examiner.
Date signed 9-6-47

VS 191

G54932

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G54932

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31 days
(e) Length of stay in Baltimore (yrs., mos., or days) 31 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County St. Marys Co.
(c) City or town Ridge P. O. (If outside city or town limits, write RURAL and give town)
(d) Street No. St. Michael's Rectory (If rural give location)
(e) Citizen of foreign country? Yes. (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. John C Rowe, S.J. (JOHN C. RAWE, S.J.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 14, 1900

8. AGE: Years	Months	Days	If less than one day
46	8	23	13 hr. 30 min.

9. Birthplace Carrollton, Illinois (Town, county, and state)

10. Usual Occupation Religious Priest

11. Industry or business

FATHER 12. Name Henry A. Rowe

13. Birthplace Germany

MOTHER 14. Maiden Name Lucy Selhorst

15. Birthplace Fieldon, Illinois

16 (a) Informant Sister - Sr. Ignatius Boyle

(b) Address Carrollton, ~~Ill~~ Ill

17 (a) Burial (b) Date thereof 9/11/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location St. Louis, Mo.

18 (a) Funeral director H. W. Mears and Son

(b) Address 805 N. Calvert Street

19 (a) SEP 8 1947 (Date received by registrar) (Huntington Williams M.D.)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7 1947 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 8 1947 to Sept. 7, 1947 and that I last saw him alive on Sept. 7, 1947.

Immediate cause of death Uremia. — Duration: 6 mos.

Due to Chronic Glomerulitis — 3 yrs

Due to

Other Conditions Hypertension c.v.r. disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: (Chronic Glomerulitis)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph L. Rowe M. D.

Address Mercy Hosp Date signed 9-2-47

VS 150 Via Pennsylvania R. R. — X

G54933

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G54933

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5304 Springlake Way
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 79 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County -------
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 5304 Springlake Way (If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Adelphine Marie Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife ---------
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Aug. 2, 1868

8. AGE: Years	Months	Days	If less than one day
79	1	4	-- hr. -- min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business -------

FATHER
12. Name Elbridge Gerry Hall
13. Birthplace Maryland

MOTHER
14. Maiden Name Amanda Bosley
15. Birthplace Cockeysville, Md.

16 (a) Informant Miss Lucy B. Hall
(b) Address 5304 Springlake Way

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meares and Son
(b) Address 805 N. Calvert Street

19 (a) SEP 8 1947 (Date rec'd by registrar) (b) Kenneth Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6th 1947, at 9:40 P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ---------- at ---------- M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G. Helfrich M.D. Medical Examiner.
Date signed Sept 7, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54934

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G54934
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. FAYETTE ST.
(c) Hospital or institution:
DON SECOURS HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7 N. FULTON AVE
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. CLARA D. WAGNER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mr. Fred R. Wagner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/27/95

8. AGE: Years 52 | Months 7 6 | Days 1 2 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation H.W.

11. Industry or business

FATHER
12. Name Chas. Prince
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Selma Marstaw
15. Birthplace Germany

16 (a) Informant Fred R. Wagner
(b) Address 7 N. Fulton Ave

17 (a) Burial (b) Date thereof Sept. 9/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Pk
Location 3801 Frederick Road

18 (a) Funeral director Harry H. Mitzfe
(b) Address 4101 E Edmondson Ave

19 (a) [redacted] Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6 1947 at 12:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1 1947 to Sept. 6 1947 and that I last saw her alive on Sept. 6 1947.

	Duration
Immediate cause of death: Cerebral apoplexy	
Due to: Hypertensive cardiovascular disease.	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul D. Mannino M. D.
Address Don Secours Hosp. Date signed 9/6/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓61

Registration No. G54935

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp 26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3525 Chesterfield Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Madeline Mary Mullen

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 213-10-9828

4. Sex: F

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: John Mullen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept. 17, 1877

8. AGE: Years 69 | Months 11 | Days 19 | If less than one day hr. min.

9. Birthplace: Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business: Baltimore Transit

FATHER
12. Name: John Hendricks
13. Birthplace: Germany

MOTHER
14. Maiden Name: Augusta ?
15. Birthplace: Germany

16 (a) Informant: Mrs. Bertha Hodgson
(b) Address: 3525 Chesterfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/47 (month) (day) (year)
(c) Cemetery or crematory: Moreland Mem. Pk.
Location: Balto., Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) SEP 8 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6, 1947, at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-5 1947 to 9-6 1947 and that I last saw h[illegible] alive on 9-6 1947

Immediate cause of death	Duration
a hypostatic pneumonia -	
Due to Cause unknown	
Due to	
Other Conditions diabetes mellitus fatty liver	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: fatty livers

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Weitzman M.D. M. D.
Address Sinai Hosp. Date signed 9-7-47

G54936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G54936 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Wilkens & Eaton Aves
(b) Street address ~~1415 W. Baltimore St~~
(c) Hospital or institution: St Agnes Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 69 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1415 W. Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elvinia V. Echo

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 30, 1877

8. AGE: Years 69 | Months 10 | Days 6 7 | If less than one day ..... hr. ..... min.

9. Birthplace Washington, D. C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Orrell
13. Birthplace Baltimore

MOTHER
14. Maiden Name Florence Stewart
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Evelyn F. McGraw
(b) Address 1415 W. Baltimore St.

17 (a) Burial (b) Date thereof 9/10/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address SEP 8 1947 Balto., Md.

19 (a) (b)
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/6/ 1947, at 8:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/27/ 1947 to 9/6/ 1947 and that I last saw h[illegible] alive on 9/6/ 1947.

Immediate cause of death Hypertensive Cardio-Vascular Renal Disease and Congestive Failure — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John W. Shaw M.D.
Address [illegible] Date signed 9/7/47

G54937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓61

Registered No. G54937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 d.
(e) Length of stay in Baltimore (yrs., mos., or days) Over 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore # 18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 423 Gilchrist Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Jefferson Council

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 213-18-7737

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Minnie May Council

6 (c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): Mar. 19, 1901

8. AGE: Years: 46 | Months: 5 | Days: 18 | If less than one day: ..... hr. ..... min.

9. Birthplace: Bacon's Castle, Surrey, Virginia (Town, county, and state)

10. Usual Occupation: Foreman

11. Industry or business: Coolidge Scrap Metal Co.

FATHER
12. Name: John G. Franklin Council
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Alice Council
15. Birthplace: Virginia

16 (a) Informant: Wife
(b) Address: Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/10/47 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olive Cem.
Location: Randallstown, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) SEP 8 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 7 1947 at 6:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/5 1947 to 9/7 1947 and that I last saw h... alive on 9/7 1947.

Immediate cause of death: Coronary Occlusion — Duration

Due to: Diabetes Mellitus

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: No
(b) Date of occurrence: ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Sanford Martin Fox M. D.
Address: Union Memorial Hosp. Date signed 9/7/47

X 1

G54938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G54938

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3913 Falls Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13y
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3913 Falls Road (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Charles Thomas Dye

3 (b) If veteran, name war —
3 (c) Social Security Account No. 212-07-4297

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Ella May Dye
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 13-1887
8. AGE: Years 60 Months 6 Days 23 If less than one day hr. min.
9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Manager
11. Industry or business A. & P. Store

FATHER
12. Name Thomas Dye
13. Birthplace Maryland

MOTHER
14. Maiden Name Laura Mayes
15. Birthplace Maryland

16 (a) Informant Mrs. Ella M. Dye
(b) Address 3913 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 9-1947 (month) (day) (year)
(c) Cemetery or crematory Poplar
Location Warren, Baltimore Co. Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) Sept 8 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 6 1947, at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943 to Sept 6 1947, and that I last saw him alive on Sept 5 1947.

Immediate cause of death	Duration
1st Cerebral Hemorrhage	12 hrs.
Due to 1st Cerebral Hemorrhage	3 yrs. ago.
Due to Hypertension	
Cardio-vascular-renal disease.	5 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dan'l Dye, M.D.
Address 846 W. 36 St. Date signed 9/6/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54939

Schnepfe

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G54939

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon Secours Hospital
(c) Hospital or institution Hospital Pulaski St
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1217 Bolton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. William Schnepfe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M.

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 25-1876

8. AGE: Years 70 | Months 9 | Days 14 | If less than one day — hr. — min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name John Henry Schnepfe
13. Birthplace Germany

MOTHER 14. Maiden Name Anna L. Schwartz
15. Birthplace Germany

16 (a) Informant George Schnepfe
(b) Address 1217 Bolton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/47 (month) (day) (year)

(c) Cemetery or crematory Greenmount Cem
Location Baltimore, Md

18 (a) Funeral director F. B. Wisbert & Son
(b) Address 310 Eutaw Place

19 (a) SEP 8 1947 (Date rec'd by registrar) Registrar Washington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6 1947 at 4:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1947 to Sept. 6 1947. and that I last saw him alive on Sept. 6 1947.

Immediate cause of death: Carcinoma of liver — Duration: ? 6 months

Due to:

Due to:

Other Conditions: Gross hematuria, — 2 years.
malaise from left kidney
(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter B. Sanger, M.D.

Address Bon Secours Hospital Date signed 9/6/47

X

G54940 B# 682208

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. G54940

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 6 weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1429 Coolesie St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country.....

3 (a) FULL NAME Patricia Kovacs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: white

6 (a) Single, ~~married, widowed, or divorced~~.

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 6-25-47

8. AGE: Years | Months: 2 | Days: 14 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER
12. Name Jacob J. Kovacs
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Magdelene Moosmon
15. Birthplace Baltimore, Md.

16 (a) Informant Jacob J Kovacs
(b) Address 1429 Collesie St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem.
Location A.A. Co.

18 (a) Funeral director Charles F. Hill
(b) Address 1501 E. Fort Ave

19 (a) Received by Registrar SEP 8 1947 (b) Huntingtown, Williams, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6 1947, at 1:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 5 1947 to Sept. 6 1947, and that I last saw her alive on Sept. 6 1947.

	Duration
Immediate cause of death: operative procedure with intensive loss of blood	
Due to: Excision of a teratoma & malignant changes of right ovule.	- 4 wks
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation Sept. 6, 1947

Major findings of operation: teratoma with malignant changes

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Katherine Sprunt

Address Union Memorial Hosp. Date signed 9-6-47 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54941

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

Registered No. G54941

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 812 W.37th St.
(c) Hospital or institution:
13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 812 W 37th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine M.Shauck.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife Walter B.Shauck.
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) May 9,1890

8. AGE: Years 57 | Months 3 | Days 28 | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name John J.Kinwin.
13. Birthplace Ireland.

MOTHER
14. Maiden Name Katie McGraw.
15. Birthplace Ireland.

16 (a) Informant Walter B.Shauck.
(b) Address 812 W.37th St.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Sept.10,47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge.
Location Pikesville Md.

18 (a) Funeral director Chenoweth & Donovan.
(b) Address 3615-17 Chestnut Ave.

19 Sep 8 1947 Date rec'd by registrar (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 6 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1935 to Sept 6 1947, and that I last saw h[illegible] alive on Sept 6 1947.

	Duration
Immediate cause of death: cerebral thrombosis	5 min.
Due to: arteriosclerosis	1 year
Due to: diabetes mellitus	2 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chenoweth Mortimer
Address 2706 St Paul St Date signed 9/8/1947
M. D.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G54942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1340

G54942 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1301 St. Paul street
(c) Hospital or institution: 11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Earl Court Apts. 1301 St. Paul street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS EDGAR BUSSEY

3 (b) If veteran, name war ---

3 (c) Social Security Account No. -----

4. Sex: Male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Elizabeth R. Bussey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 22, 1867

8. AGE: Years 79 | Months 8 | Days 15 | If less than one day hr. min.

9. Birthplace Emmitsburg, Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Board of Education N.Y.

FATHER
12. Name James Thomas Bussey
13. Birthplace Northeast, Cecil Co. Md.

MOTHER
14. Maiden Name Julia Elder
15. Birthplace Emmitsburg, Md.

16 (a) Informant Mrs. John Carroll
(b) Address 1301 St. Paul street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/47 (month) (day) (year)
(c) Cemetery or crematory St. Joseph's
Location Emmitsburg, Md.

18 (a) Funeral director Chas. J. Evans Son Inc.
(b) Address 118 N. Mt. Royal Ave.

19 SEP 8 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1935 to Sept 7 1947, and that I last saw h. alive on Sept 7. 1947.

Immediate cause of death — Duration
Shock — 8 hrs
Due to Kidney Colic (Passage of Kidney Stone) — 8 hrs.
Due to —
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature E. K. Hayward, M. D.
Address 115 E Eager St Date signed 9/8/47

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C54943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. C54943

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4801 Holder Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4801 Holder Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William F. Grigoleit

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	M

6 (b) Name of husband or wife Martha E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 28-1885

8. AGE: Years	Months	Days	If less than one day
62	5	10	hr. min.

9. Birthplace Germany
(Town, county and state)
10. Usual Occupation machinist
11. Industry or business

FATHER
12. Name Julius Grigoleit
13. Birthplace Germany

MOTHER
14. Maiden Name Charlotte Christlieb
15. Birthplace Germany

16 (a) Informant Mrs. Martha Grigoleit
(b) Address 4801 Holder Ave.

17 (a) Cremation (b) Date thereof 9-10-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Md.

18 (a) Funeral director Leonard J. Luck
(b) Address 5305 Harford Road.

19 (a) SEP 8 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-7 19 47, at 2 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Gillis M.D.
Medical Examiner.
Date signed 9-7-47

G54944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 169

Registered No. G54944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2600 Garrett ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William E. Good, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	S

6 (b) Name of husband or wife J

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 16. 1926

8. AGE: Years	Months	Days	If less than one day
21	7	20	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Attendant

11. Industry or business

FATHER 12. Name Wm E Good. Sr

13. Birthplace Penna

MOTHER 14. Maiden Name Marguerite Holshouser

15. Birthplace Ms.

16 (a) Informant Mr. Wm E Good-Sr

(b) Address 2600 Garrett Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-9-47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Balto

18 (a) Funeral director R. J. Ruck

(b) Address 5305 Harford Rd.

19 (a) SEP 8 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5th 1947, at 11 43 A.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH

Fractured skull

Intracranial Hemorrhage

Lacerations of brain

Other Conditions Multiple contusions, bruises - lacerations

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 9/5/47 9/7 approx. 2 A.M.

(b) Where did injury occur? B.&O. R.R. tracks near Harrison & Eastern Ave.

(c) Did injury occur at home, on farm, industrial place, in public place? B.&O. R.R. Prop. While at work? No

(d) Means of injury Ped. struck by freight car

23. Signature Howard J. Mercer M.D.

Medical Examiner.

Date signed 9-5-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164a

Registered No. G54945

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3238 Glendale ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3238 Glendale Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Behr (BEHR)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Drucilla

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 3 - 1889

8. AGE: Years	Months	Days	If less than one day
58	8	4	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation carpenter

11. Industry or business

FATHER
12. Name Edward Behr
13. Birthplace Md

MOTHER
14. Maiden Name Laura Daniels
15. Birthplace Md.

16 (a) Informant Mrs. Drucilla Behr
(b) Address 3238 Glendale Ave

17 (a) Burial (b) Date thereof 9-10-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Pk.
Location Md.

18 (a) Funeral director Leonard J. Luck
(b) Address 5305 Harford Rd.

19 (a) SEP 8 1947 (b) Hunter Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7 19 47 at 1:30 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Hanging

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-7-47 at 12:30 A. M.
(b) Where did injury occur? 3238 Glendale
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Hanged with rope

23. Signature Earl K. Brown M.D.
Medical Examiner.

Date signed 9-8-47

PRINTED IN U.S.A. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK. ENGRAVED FOR BINDING

54946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

832a

Registered 54946

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1309 Holbrook St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1309 Holbrook St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary T. Wheeler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Wm. H. Wheeler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 21- 1872

8. AGE: Years	Months	Days	If less than one day
75	5	16	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name George W. Marshall
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Lavina Preston
15. Birthplace Balto. Md.

16 (a) Informant Lydia A. Hajm
(b) Address 1300 Holbrook St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 11-47 (month) (day) (year)
(c) Cemetery or crematory Balto. Cemetery
Location North Ave. + Gay St.

18 (a) Funeral director John A. Miller
(b) Address 2324 Jefferson St.

19 [redacted] (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7, 1947, at 4:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2, 1947 to Sept. 7, 1947 and that I last saw her alive on Sept. 7, 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	8 months
Due to Hypertension	?
Due to	
Other Conditions Arteriosclerosis	?

(Include pregnancy within 3 months of death)

Date of operation none
Major findings of operation: ~~11~~
of autopsy: ~~11~~

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ~
(b) Date of occurrence ~ at ~ M
(c) Where did injury occur? ~
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ~ While at work? ~
(Specify type of place)
(e) Means of injury ~

23. Signature Frank M. Ogden M. D.
Address 2701 N. Calvert St. Date signed Sept. 8, 47

X

G54947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G54947
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A
(b) Street address 2166 Hollins St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2166 Hollins St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Keen

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Ella V. Keen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 2 - 1879

8. AGE: Years	Months	Days	If less than one day
67	9	4	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Guard City Jail
11. Industry or business

FATHER
12. Name Conrad Dr. Keen
13. Birthplace Maryland

MOTHER
14. Maiden Name Fanny K. Knight
15. Birthplace Maryland

16 (a) Informant Mrs. Ella V. Keen
(b) Address 2166 Hollins St.

17 (a) Burial (b) Date thereof Sept 9-1949
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md.

18 (a) Funeral director George L. Schwatt
(b) Address 2101 Frederick Ave

SEP 8 1949 Twittington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/6 1949 at 2:00 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 9/8/49

X

654948 BCH 680622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G54948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division Street
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1327 W. Lafayette Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Patricia Grooms

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-30-47

8. AGE: Years | Months | Days: 13 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name David Grooms
13. Birthplace

MOTHER
14. Maiden Name Georgia Howe
15. Birthplace Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Destroyed by Provident Hosp.

18 (a) Funeral director
(b) Address

19 SEP 8 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1947, at 10 55 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 28 1947, to May 3 1947, and that I last saw her alive on May 3 1947.

Immediate cause of death: Idiopathic Diarrhea — Duration: 6 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Dehydration, Pulmonary Congestion

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Percival C. Smith M. D.
Address 1514 Division St. Date signed 5-22-47

G54949

HEALTH DEPARTMENT—CITY OF BALTIMORE

BCH 687975 V.161a G54949

CERTIFICATE OF DEATH

1. PLACE OF DEATH Volunteers of America Hospital — Registered No.

CITY OF BALTIMORE: (No. 5214 St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 15 yrs. 1 mos. 1 da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Bright — If U. S. Veteran specify WAR

(a) Residence: No. 2117 Clifton Ave. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	W	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6. DATE OF BIRTH (month, day, year): Sept. 1, 1947

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1	13 hrs.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: —

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.: —

10. Date deceased last worked at this occupation (month and year): —

11. Total time (years) spent in this occupation: —

12. BIRTHPLACE (city or town) (State or country): Baltimore, Md.

FATHER

13. NAME: Reynolds Bright

14. BIRTHPLACE (city or town) (State or country): Harrington Delaware

MOTHER

15. MAIDEN NAME: Betty Elizabeth Wyatt

16. BIRTHPLACE (city or town) (State or country): Harrington Delaware

17. INFORMANT: Mother
(Address) 2117 Clifton Ave.

18. BURIAL, CREMATION, OR REMOVAL
Place [redacted] Date SEP 8 1947 19

19. UNDERTAKER: Commissioner of Health
(Address)

SEP 8 1947 Huntington Williams M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year): Sept. 2, 1947

22. I HEREBY CERTIFY, That I attended deceased from Sept. 1, 1947 to Sept. 2, 1947

I last saw he alive on Sept. 2, 1947 Death is said to have occurred on the date stated above, at 12:15 P.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Asphyxiation Cause	Sept. 2
Other contributory causes of importance:	

Was an operation performed? no Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy? no

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) J. Hullard M. D.

(Address)

INFORMATION—Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V0 2

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

054950 54948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 054950

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 427 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John King

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 62 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School SEP 8 1947

18 (a) Funeral director Commissioner of Health

(b) Address

19 (SEP 8 1947) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-24 1947, at 8 55 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Hypertensive Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ... at ... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature ... M.D.
Medical Examiner.

Date signed 8-25-47

VS 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4208 Orchard Rd

G54951

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G54951 Registered No.

1312

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 431 S. Augusta Avenue
(c) Hospital or institution:
Home 20-8
(d) Length of stay in hospital or inst. (yrs., mos., or days) -
(e) Length of stay in Baltimore (yrs., mos., or days) -

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 431 S. Augusta Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Walter U. Fox

3 (b) If veteran, name war: no
3 (c) Social Security Account No. -

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26, 1875

8. AGE: Years 71 | Months 2 3 | Days 12 | If less than one day ... hr. ... min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Bell Telephone Co.

FATHER
12. Name Uriah Fox
13. Birthplace Germany

MOTHER
14. Maiden Name Lizzie Brown
15. Birthplace Ireland

16 (a) Informant Wm. H. Fox
(b) Address 208 S. St. Harrisburg, Pa.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept. 8 (month) (day) (year)
(c) Cemetery or crematory East Harrisburg, Pa.
Location

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

Date filed (by registrar) 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7th 1947, at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1947 to Sept 7 1947, and that I last saw h[illegible] alive on Sept 6 1947.

Immediate cause of death — Duration

Chronic Myocarditis

Due to

Due to

Other Conditions C.V.D. disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. H. Carruthers

Address 4209 Hurd Ave Date signed M. 9/8/47 D.

VS 150

9D

G54952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G54952

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5660 Ravon ave.
(c) Hospital or institution: 26-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5660 Ravon ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME Charles Henry Leaman

3 (b) If veteran, name war None

3 (c) Social Security Account No. 212-26-2849

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of ~~husband~~ wife Ida Westley Leaman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1883

8. AGE: Years 64 | Months 7 | Days 6 | If less than one day hr. min.

9. Birthplace Reading, Penna. (Town, county and state)

10. Usual Occupation Retired

11. Industry or business Mech. Engineer

FATHER
12. Name Edwin T. Leaman
13. Birthplace Lancaster Co., Penna.

MOTHER
14. Maiden Name Marguerite Duncan
15. Birthplace Penna

16 (a) Informant William W. Leaman
(b) Address 3815 Hayward ave, Balto. 15

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof (month) Sept. (day) 8, (year) 1947

(c) Cemetery or crematory Mt. Olivet Cemetery
Location 917 W. Fayette St. Baltimore Md.

18 (a) Funeral director John Burns Hope
(b) Address Towson, Md.

19 (a) Date rec'd by local reg. SEP 9 1947 (b) Registrar's signature Livingston Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8, 1947 at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1947 to Sept. 1947 and that I last saw h[im] alive on Aug. 2 1947

Immediate cause of death Carcinoma of stomach — Duration

Due to —

Due to —

Other Conditions Extensive carcinosis of abdomen

(Include pregnancy within 3 months of death)

Date of operation Aug. 1946

Major findings of operation: Carcinoma of stomach.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Henry Hope

Address 4218 Harford Rd. Date signed Sept 9 1947

G54953 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G54953

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write correct age in especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1134 Homewood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1134 Homewood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hugh A Starr

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex: Male — 5. Color or race: White — 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Mary A

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 22 1875

8. AGE: Years 71 | Months 9 | Days 15 | If less than one day hr. min.

9. Birthplace Va (town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER — 12. Name Unknown

13. Birthplace "

MOTHER — 14. Maiden Name ?

15. Birthplace ?

16 (a) Informant Annie Moore

(b) Address 1134 Homewood Ave

17 (a) Final (Burial, cremation, or removal) (b) Date thereof 9/10/47 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Baltimore Md

18 (a) Funeral director Wilbur Coffin Inc

(b) Address 2142 Park Ave

SEP 9 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7 1947, at 10? M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/6 1947 to 9/7 1947 and that I last saw h[illegible] alive on 9/7 1947

Immediate cause of death Coronary Disease — Duration Sudden

Due to Arteriosclerotic Cardio-Vascular ?

Due to Renal Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph S. Blum M. D.

Address 1206 E. Preston St Date signed

X

G54954

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G54954
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Sq Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 516 W 32nd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Hudgins
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Katie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 17, 1882

8. AGE: Years	Months	Days	If less than one day
65	5	20	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Grain Feeder
11. Industry or business

FATHER
12. Name Thomas Hudgins
13. Birthplace Maryland

MOTHER
14. Maiden Name Catharine Brenner
15. Birthplace Md

16 (a) Informant Mrs Carolyn M Merson
(b) Address 516 W 32nd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore Md

18 (a) Funeral director Wilson & Son
(b) Address 2174 Pratt

19 SEP 9 1947 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 6 1947, at 12:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-29 1947, to 9-6 1947, and that I last saw him alive on 9-5 1947

Immediate cause of death Degenerative myocardial disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(c) Means of injury
23. Signature Joseph B. Schook M. D.
Address Franklin Sq. Hosp Date signed 9-6-47

G54955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G54955

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 520 N. Charles St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 520 N. Charles St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ABBEY E. KRAUSE

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	W.

6 (b) Name of husband or wife Gustav
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 12 - 1878

8. AGE: Years	Months	Days	If less than one day
68	8	14	25 hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ? Cooke
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen. ?
15. Birthplace Balto Md.

16 (a) Informant Mrs Janis Sumers
(b) Address 4505 Reisterstown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk Cem
Location

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St Paul St

19 SEP 9 1947 (Date rec'd by registrar) (b) Washington Williams, M.E. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6 1947, at 6 50 M

21. I certify that death occurred on the date above stated, that I attended deceased from 9/1 1947 to 9/6 1947, and that I last saw h alive on 9/6 1947.

Immediate cause of death Hypertensive cardio-vascular disease — Duration 6 mos

Due to

Due to

Other Conditions Cerebral hemorrhage — 2 days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin Weller M. D.
Address 1030 Wilkens Ave Date signed 9/8/47

G54956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G54956

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2601 Roslyn Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2601 Roslyn Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles W. Sees

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Mary E. Sees

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1862

8. AGE: Years 85 | Months 5 | Days 20 | If less than one day hr. min.

9. Birthplace Pittsburgh, Pa. (Town, county, and state)

10. Usual Occupation Hotel Keeper

11. Industry or business

FATHER 12. Name John Sees

13. Birthplace Germany

MOTHER 14. Maiden Name Mary Zengler

15. Birthplace Alsace Lorraine

16 (a) Informant John R. Sees

(b) Address Pines On The Severn, Arnold Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 10, 1947 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Old Frederick Road

18 (a) Funeral director Wm. Cook Sons

(b) Address 1217 St. Paul St.

1947 SEP 9 (Date rec'd by registrar) Hattie for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-7- 1947 at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-6- 1947 to 9-7- 1947 and that I last saw him alive on 9-6- 1947.

Immediate cause of death: Chronic Myocarditis — Duration: 4 yrs or more

Due to

Due to Old. Age.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Inglis C. Blake M. D.

Address Med. Arts Bldg. Date signed

G54957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G54957

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3215 Kenyon Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA L. GRAY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	MARRIED

6 (b) Name of husband or wife GEORGE B. GRAY
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-11-74

8. AGE: Years	Months	Days	If less than one day
73	6	20	hr. 27 min.

9. Birthplace Edgewood, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm B. Litzinger
13. Birthplace Md.

MOTHER
14. Maiden Name Susan R. Falconer
15. Birthplace Md.

16 (a) Informant Geo. B Gray
(b) Address 3215 Kenyon ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/10/47 (month) (day) (year)
(c) Cemetery or crematory Cokesbury Mem. Cem
Location Kingsdon Harford Co. Md.

18 (a) Funeral director Wm Cook Jr.
(b) Address 121 S. St Paul St

19 SEP 9 1947 (Date rec'd by Registrar) (Signature of Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-7-1947, at 2 25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-27-1947 to 9-7-1947, and that I last saw h. e. alive on 9-7-1947.

Immediate cause of death Pulmonary Embolism — Duration

Due to Pelvic phlebothrombosis

Due to Fracture of Left Hip

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 26/3
(a) Accident, suicide, or homicide
(b) Date of occurrence 8-27-47 at 9 A M
(c) Where did injury occur? Baltimore (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? (Specify type of place)
(e) Means of injury Fell to floor Uppsala

23. Signature Anthony F. DiPaula M.D.
Address Dr Joseph's Hosp Date signed 9/7/47

Carl E. Rogers, M.D.

C54958 B[illegible] B-75249 BALTIMORE CITY HEALTH DEPARTMENT Registered No. C54958
CERTIFICATE OF DEATH 107

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 6-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1516 E. Baltimore, St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Patsy Prough

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 7. 1947

8. AGE: Years	Months	Days	If less than one day
	5	1	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Howard Prough
13. Birthplace Pa.

MOTHER
14. Maiden Name Viola Gift
15. Birthplace Iowa

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/47 (month) (day) (year)
(c) Cemetery or crematory Gospel Hall
Location Towson Md.

18 (a) Funeral director Fulton & Long
(b) Address 1214 Cook St.

(a) SEP 8 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8 - 1947 at 1 20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 9-8- 1947. and that I last saw h[illegible] alive on 9-8- 1947.

Immediate cause of death	Duration
Bronchopneumonia	
Due to Acute Nutritional	
Due to Deficiency	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Edwards M. D.
Address D. H. H. Date signed 9-8-47

X

C54959

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

Registered No. C54959

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 618 S. Washington St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William H KENNY (KENNEY)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Elizabeth C

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6 1909

8. AGE: Years	Months	Days	If less than one day
38	3	2	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Helper

11. Industry or business Maryland Dry Dock Co Baltimore

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Elizabeth C Kenney
(b) Address 618 S Washington St

17 (a) Burial Inurn (Burial, cremation, or removal) (b) Date thereof 9/11/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Wilson & Dolan
(b) Address 1317 E Lexington St

19 SEP 9 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH September 8 1947, at 7 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Fractured skull
Intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-8-47 at 1:00 A M(?)
(b) Where did injury occur? Monument Ave & Aisquith
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? no
(d) Means of injury Blunt force

23. Signature George H. Merrill M.D. Medical Examiner.
Date signed 9/8/47

G54960

CM. 111286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G54960

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE.
(c) Hospital or institution: Baltimore City Hospitals 7-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Months
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 939 N. Chester ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Ruperti

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Div.

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 26 - 1881

8. AGE: Years 65 | Months 9 | Days 12 | If less than one day ... hr. ... min.

9. Birthplace MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Tilhon Corp
(b) Address 517 E Lanvale St

19 9-9-1947 Wayne Williams M.D.
(Date received by registrar) (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8 - 1947, at 10.25A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-9-47 1947, to 9- 8 - 1947, and that I last saw him alive on 9 -8 - 1947

Immediate cause of death: Carcinoma of Sigmoid & generalized metastasis — Duration: 6 months

Due to

Due to

Other Conditions Generalized Arteriosclerosis — Duration: Years
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: Carcinoma of Sigmoid

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 4940 Eastern Ave Date signed 9-7-47

G54961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 83a

Registered No. G54961

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 818 Beaumont Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-10
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 818 Beaumont Ave. 12 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAUDE ESTELLE ATKINS

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife J. Dorsey Atkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 26, 1882

8. AGE: Years	Months	Days	If less than one day
65	5	10	hr. min.

9. Birthplace Martinsburg, W. Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas Edward Matthews
13. Birthplace Martinsburg, W. Va.

MOTHER
14. Maiden Name Alice Rebecca Tharp
15. Birthplace Martinsburg, W. Va.

16 (a) Informant Mr. J. Dorsey Atkins
(b) Address 818 Beaumont Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/9.47 (month) (day) (year)
(c) Cemetery or crematory Rosedale Cem.
Location Martinsburg, W. Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 9 1947 (Date rec'd by registrar) (b) [signature] M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6, 1947, at 8:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1947, to Sept 6 1947, and that I last saw he alive on Sept 5 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	6 hours
Due to	
Hypertension	Yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.
Address 20 E. Preston St., Date signed 9/11/47

X

G54962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registration No. G54962

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Charles & Yniversity Pkwy.

(c) Hospital or institution: Northway Apts.

(d) Length of stay in hospital or inst. (yrs., mos., or days): 12

(e) Length of stay in Baltimore (yrs., mos., or days): life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Md (b) County:

(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No.: Charles & University Pkwy.
(Northway Apts.)
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: HOLMES I. METTEE

3 (b) If veteran, name war: none

3 (c) Social Security Account No.:

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Elsye Boyd Mettee

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 5, 1885

8. AGE: Years: 62 Months: 4 Days: 1 If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Photo.

11. Industry or business: Self

FATHER
12. Name: Norris I. Mettee
13. Birthplace: Md.

MOTHER
14. Maiden Name: Mary Holmes
15. Birthplace: Md.

16 (a) Informant: Mr. N. Boyd Mettee
(b) Address: 3711 Chesholm Rd. 16

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9/9/47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 SEP 9 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 6, 1947, at 1:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 25 1947 to Sept 6 1947 and that I last saw h[illegible] alive on Sept 5 1947

Immediate cause of death	Duration
Acute Cardiac Dilatation & Fibrulation	
Due to Chronic Rheumatic Carditis Chronic Nephritis	
Due to Arter-Sclerosis	
Other Conditions Anemia - Edema - Decompensation	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide:

(b) Date of occurrence: at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury:

23. Signature: Walter A Anderson M. D.

Address: 3601 Hamilton Drive Date signed: Sept. 8-47

C54963

BCH 88750

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 160c

C54963 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address RAYNER AVE. + DUKELAND
(c) Hospital or institution: West Baltimore General Dr
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ hrs,
(e) Length of stay in Baltimore (yrs., mos., or days) 2½ hrs,

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto 29-Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 142 Denison St. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Hetman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of ~~husband or wife~~ Mother Agnes Mary Hetman
6 (c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1947

8. AGE: Years	Months	Days	If less than one day
			2 hr. 30 min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Frank Daniel Hetman
13. Birthplace Balto, Md.

MOTHER
14. Maiden Name Agnes Mary McKeown
15. Birthplace Phila Pa

16 (a) Informant: Frank D Hetman
(b) Address 142 Denison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 9 1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director Henry A Wolfe
(b) Address 4101 Edmondson Ave

19 (SEP 9 1947) (Date rec'd by registrar) (Huntington Williams, M.D.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8 1947, at 4:32 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2 P.M. 9/8/47 19..., to 4 P.M. 9/8/47. and that I last saw HER alive on 9/8/47 19...

Immediate cause of death ATALECTASIS, Bilateral — Duration 2hr

Due to

Due to

Other Conditions Prematurity Dyp
Prematurity
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frances L Grumbine M. D.
Address W. Balt. Gen. Hosp. Date signed 9/8/47

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G54964

BCH G87957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1159

Registered No. G54964

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 1710 No Appleton St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Snyder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 7-1947

8. AGE: Years | Months: | Days: 1/2 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Isadore Snyder
13. Birthplace Galto Md

MOTHER
14. Maiden Name Rebecca Bloom
15. Birthplace Annapolis Md

16 (a) Informant Isadore Snyder
(b) Address 1710 No Appleton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-9-47 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Herring Law

18 (a) Funeral director Jack Lewis Inc
(b) Address 210 Eutaw Place

19 SEP 9 1947 (b) Huntington Williams M.D.
(Date received by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8 1947, at 8:5 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7 1947 to Sept 8 1947 and that I last saw h alive on Sept 8 1947

Immediate cause of death: Cardiac insufficiency failure — Duration

Due to: Prematurity

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Johnns

Address Sinai Hosp Date signed 9/9/47 M.D.

G54965

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G54965 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2510 Elsinor Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MORRIS LIBAVER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Sylvia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1878

8. AGE: Years 69 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name David

13. Birthplace Lith

MOTHER 14. Maiden Name unknown

15. Birthplace Lith

16 (a) Informant Sylvia Libauer

(b) Address 2510 Elsinor Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-9-47 (month) (day) (year)

(c) Cemetery or crematory Beth Tfiloh

Location Windsor Mill Road

18 (a) Funeral director Jack Lewis Inc

(b) Address 2160 Eastern Ave

SEP 9 1947 (Date rec'd by Registrar) (Signature) for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 8 1947, at 12 55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/7 1947 to 9/8 1947 and that I last saw h. 1m alive on 9/8 1947

Immediate cause of death	Duration
Poss Ruptured ABDOMINAL AORTA ANEURYSM	
Due to Arteriosclerosis A.S.H.D.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Maurice A. Perillo M.D.

Address Sinai Hosp. Date signed 9/8/47

X

G54966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G54966

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 638 S. Oldham St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Andrews Rau

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	White	Married

6 (b) Name of husband or wife William Rau
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6, 1884

8. AGE: Years	Months	Days	If less than one day
63	6	2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Andrews
13. Birthplace Baltimore

MOTHER
14. Maiden Name Bertha Beck
15. Birthplace Germany

16 (a) Informant William Rau
(b) Address 638 S. Oldham St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 11- (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Arlington St

SEP 9 1947 (date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8 1947, at 11:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 6 1947, to Sept 8 1947, and that I last saw her alive on Sept 8 1947.

Immediate cause of death	Duration
Subarachnoid hemorrhage (cerebral)	
Due to Hypertensive cardio-vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert D. Johnson M. D.
Address Mercy Hospital Date signed 9/8/47

G54967 BCH # 87862 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 160a Registered No. G54967

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland St.
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2774 Tivoli Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Rosemary Darling

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 5 1947

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Bruce Darling
13. Birthplace Ga

MOTHER
14. Maiden Name Rose Gagliano
15. Birthplace Baltimore Md.

16 (a) Informant Rose Darling (Mather)
(b) Address 2774 Tivoli Ave

17 (a) Burial (b) Date thereof Sept. 9 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

SEP 9 1947 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8 1947 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 5 1947 to Sept 8 1947 and that I last saw h[illegible] alive on Sept 8 1947

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Atelectasis & prematurity	
Contributory Congenital Heart Disease	
Due to Calculus accident	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Irvin W. Cushner
Address Sinai Hospital Date signed 9-8-47 D.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G54968 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4004 Pennington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4004 Pennington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Michel

3 (b) If veteran, name war: US
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Eva
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 22-1858
8. AGE: Years 89 | Months 1 | Days 16 | If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Clerk Retired
11. Industry or business P.R.R.

FATHER
12. Name Henry Michel
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Schwick
15. Birthplace Germany

16 (a) Informant Eva Michel
(b) Address 4004 Pennington Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 11 47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md
18 (a) Funeral director Williams & Son
(b) Address 1214 E Coal St
SEP 9 1947 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8 1947, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 47 to Sept 8 19 47
and that I last saw h alive on Aug 29 19 47.

Immediate cause of death Coronary Thrombosis
Due to Arteriosclerosis
Due to
Other Conditions Fractured left femur
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: 3 months

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 25.5
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 8-25-47 at 9 A.M.
(c) Where did injury occur? 4004 Pennington Ave (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Bedroom (Specify type of place) While at work? no
(e) Means of injury fell from chair to floor

23. Signature Paul Thompson M. D.
Address 623 E N. Ave. Date signed 9/4/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54969 K-113159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V.13B

Registered No. G54969

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. [illegible] Baltimore St. & Green St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dennis Howard

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not given

8. AGE: Years	Months	Days	If less than one day
? 65			hr. min.

9. Birthplace Ireland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Howard
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Flannery
15. Birthplace Ireland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location Germantown Road

18 (a) Funeral director J. J. Zapf Funeral Home
(b) Address 1218 Light St.

SEP 9 1947 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH September 2 1947, at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 19 1947, to Sept. 2 1947, and that I last saw him alive on Sept. 2 1947.

	Duration
Immediate cause of death: Respiratory failure	4 hrs.
Due to: Tuberculosis of lungs far advanced	5 wks+
Due to:	
Other Conditions: Hypertension due to Nephrosclerosis; Subacute bacterial	

(Include pregnancy within 3 months of death)

Date of operation none
Major findings of operation: none
Subacute aortic
of autopsy valve endocarditis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Joseph J. Bowen Jr. M. D.
Address Balto City Hosp. Date signed 9-6-47

G54970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G54970 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2103 E. Federal St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mths

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Dorchester
(c) City or town Cambridge
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8 Cherry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary O. Wheatley

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Martin L. Wheatley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 21st 1877

8. AGE: Years 69 | Months 8 | Days 19 | If less than one day hr. min.

9. Birthplace Dorchester Co. Md.
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Allett Cox
13. Birthplace Dorchester Co. Md.

MOTHER
14. Maiden Name Sarah Thomas
15. Birthplace Dorchester Co. Md.

16 (a) Informant Miss Eliz. Cox
(b) Address 2103 E. Federal St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 11 47 (month) (day) (year)
(c) Cemetery or crematory Dorchest Memorial
Location Cambridge, Md.

18 (a) Funeral director Lassahn & Linthicum
(b) Address 4401 Belair Rd.

SEP 9 1947
(Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9th 1947, at 3:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 14 1947 to Sept. 8 1947 and that I last saw h[illegible] alive on Sept. 8, 1947

Immediate cause of death	Duration
Cerebral Hemorrhage	3 days.
Due to Hypertensive Cardiovascular disease	2 mo.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. A. Symmetts M.D.
Address Medical Arts Bldg Date signed 9/9/47

G54971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G54971 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere & Bellona Avenues
(c) Hospital or institution:
Edgewood Nursing Home 14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 weeks
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) ~~County~~ City of Baltimore
(c) City or town 1429 Bolton Street
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1429 Bolton Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sara Sadtler Emory

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife Single
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May-17-1869

8. AGE: Years	Months	Days	If less than one day
78	3	21	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Daniel Hopper Emory
13. Birthplace Centreville, Maryland

MOTHER
14. Maiden Name Mary Catharine Sadtler
15. Birthplace Baltimore Co., Maryland

16 (a) Informant Mrs. Charles R. Emory
(b) Address 104 W. Penna. Ave., Towson, Md.

17 (a) Burial (b) Date thereof Sept-10-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Baltimore, Maryland

18 (a) Funeral director Stewart & Mowen Company
(b) Address 105 W. North Avenue, City.

19 (a) 1947 (b) Thomas Livingston Williams, M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7th Sept 1947 at 3.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 18 Aug 1947 to 7 Sept 1947, and that I last saw her alive on 7 Sept 1947.

Immediate cause of death	Duration
Hypertensive Cardiovascular Disease	?
Chronic Nephritis	
Due to Arteriosclerosis, generalized ? Senility	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph E. Muse Jr. M. D.
Address 3311 St Paul St. Date signed 8 Sept 47

X

G54972 LW 113606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G54972 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Exact age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2109 Bank St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis Polomski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 7 1939

8. AGE: Years	Months	Days	If less than one day
8	2	-	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name (Deceased)
13. Birthplace

MOTHER
14. Maiden Name Frances Wisniewski
15. Birthplace Md.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 10/47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore

18 (a) Funeral director Fred W. Ozarowski
(b) Address 1930 Eastern Ave.

19 (a) SEP 9 1947 (Date rec'd by registrar) (b) Washington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7- 19 47, at 2:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 5 19 47 to Sept. 7 19 47 and that I last saw her alive on Sept. 7 19 47

Immediate cause of death	Duration
Acute myeloid leukemia	- mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmund B. Beahan M. D.
Address Baltimore Date signed 7 Sept 47

AGCo. 5-11 2500

G54973

HEALTH DEPARTMENT—CITY OF BALTIMORE G54973

CERTIFICATE OF DEATH

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 605 George St., Ward)

Registered No.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Bonnie Reed

(a) Residence: No. 605 George St., 17-1 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

6a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of Garfield Reed

6. DATE OF BIRTH (month, day, year) Dec 7 1885

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	-	29	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, lawyer, bookkeeper, etc. Housework
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Danville Va

FATHER
13. NAME Martin Neal
14. BIRTHPLACE (city or town) (State or country) Danville Va

MOTHER
15. MAIDEN NAME Jane Martin
16. BIRTHPLACE (city or town) (State or country) Virginia

17. INFORMANT Mrs Lottie Smith
(Address) 605 George St

18. BURIAL, CREMATION, OR REMOVAL
Place Mt Calvary Date Sept 10 1947

19. UNDERTAKER Wm Fate Jackson
(Address) 716 Penna Ave

20. Sept 9 1947 Huntington Williams M.D.
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Sept 6 1947

22. I HEREBY CERTIFY, That I attended deceased from Dec 7 1947, to Sept 6 1947
I last saw h alive on Dec 7 1947 death is said to have occurred on the date stated above, at 4 P m.

The principal cause of death and related causes of importance were as follows:

Bronchiectasis

Date of onset ?

Other contributory causes of importance

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury 19
Where did injury occur?
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) H. Hollaway M.D.
(Address) 632 W Franklin St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G54974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1248

G54974

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 707 N. Curley Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 707 N. Curley Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel H. Neal

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No.:

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: divorced

6 (b) Name of husband or wife: Constance (nee Bagwell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 30, 1898

8. AGE: Years	Months	Days	If less than one day
49	5	7	hr. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation: Machinist
11. Industry or business: Amer. Coat Pad Co.

FATHER
12. Name: Robert Neal
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Mary Jones
15. Birthplace: Maryland

16 (a) Informant: Mrs. Constance Neal
(b) Address: 1307 Rice Ave. Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/10/47 (month) (day) (year)
(c) Cemetery or crematory: Balto. National
Location: 5501 Frederick Rd.

18 (a) Funeral director: Charles E. Schimunek
(b) Address: 2601 E. Madison Street

SEP 9 1947 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/6 1947 at 5:[illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1944 to Sept 6 1947 and that I last saw h[illegible] alive on Sept 5 1947.

Immediate cause of death	Duration
Arteriosclerotic Cardio vascular renal disease	?
Due to	
Due to	
Other Conditions Carcinoma of Liver (Include pregnancy within 3 months of death)	3 years

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert E. Sikorsky M.D.
Address 2939 E. Fairmount Ave. Date signed 9/7/47

1312

G54975

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1947

Registered No. G54975

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2819 E. Biddle D.O.A St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) +-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2819 E. Biddle St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Hunter

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	widowed

6 (b) Name of husband or ~~wife~~ Matthew D. Hunter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Ireland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Arthur Hunter - son
(b) Address 2819 E. Biddle Street

17 (a) Burial (b) Date thereof 9/9/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Baltimore
Location North Ave. & Rose St. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

SEP 9 1947 Hattie Williams M.D.
(Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/6 1947, at 8:45 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic G.V
Disease & Chronic Myocardial
Due to Degeneration

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Sutbrink M.D.
Medical Examiner.
Date signed 9/6/47

G54976

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

Registered No. G54976

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1811 St. Paul St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1811 St. Paul St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME NORA R. FURNESS

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9, 1873

8. AGE: Years	Months	Days	If less than one day
74	4	28	hr. min.

9. Birthplace Somerset Co., Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Alexander W. Furness
13. Birthplace Somerset Co., Md.

MOTHER
14. Maiden Name Marie H. Phoebus
15. Birthplace Somerset Co., Md.

16 (a) Informant Mrs. Chelf
(b) Address 1809 Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/10/47 (month) (day) (year)
(c) Cemetery or crematory All Saints Cem.
Location Princess Anne, Somerset Co. Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 SEP 9 1947 (Date rec'd by registrar) Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7, 1947, at 8:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1947 to Sept 7 1947, and that I last saw h[illegible] alive on Sept. 6 1947

Immediate cause of death: Cerebral Hemmorrhage — Duration
Due to: Hypertension
Due to: Arteriosclerosis
Other Conditions: Anemia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter A Anderson M. D.
Address 3601 Shannon Drive Date signed Sept 8-47

G54977

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 9-21

Registered No. G54977

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 540 Gold St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-3
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 540 Gold St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adeline Carter

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-1-1890

8. AGE: Years 57 | Months 6 | Days | If less than one day hr. min.

9. Birthplace S. Carolina (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Smith
13. Birthplace S. Carolina

MOTHER
14. Maiden Name Louise Smith
15. Birthplace S. Carolina

16 (a) Informant Lizzie Alston
(b) Address 540 Old Gold St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/10/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Wm. H. Kelso
(b) Address 1303 Pressalman

SEP 9 1947 (Date rec'd by Registrar) Huntington Williams Registrar

SEP 9 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 Sept. 1947, at 10. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive cardio-vascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kommer Jr. M.D. Medical Examiner

Date signed 8 Sept. 1947

X

G54978

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G54978 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY. WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1601 E. 31st St.
(c) Hospital or institution: 9-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1601 E. 31st St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM GRAULING

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 218-36-2892

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Julia Schmidt

6 (c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): Oct. 11. 1891

8. AGE: Years: 55 | Months: 11 | Days: 26 | If less than one day: 27 hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: Equitable Trust Co. formerly Capt. Fire Dept.

11. Industry or business: Retired

FATHER
12. Name: Frederick Grauling
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: Annie Fink
15. Birthplace: Baltimore

16 (a) Informant: Mrs. Julia Grauling (Wife)
(b) Address: 1601 E. 31st. St. Baltimore 18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 9. 194 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cem.
Location: Baltimore Md.

18 (a) Funeral director: HENRY SANDER & SONS. INC.
(b) Address: North Ave. & Broadway. 13

SEP 6 1947 (Date received by registrar) Christopher Williams, M.D.

SEP 9 50 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7. 1947 at 12.01 AM

21. I certify that death occurred on the date above stated; that I attended deceased from August 6 1947 to Sept. 6 1947, and that I last saw h[illegible] alive on Sept. 6 1947.

Immediate cause of death: Metastatic Carcinoma of liver
Primary site undetermined — Duration: 0

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature Wm. L. Grauling Jr.
Address 12. Clara St. Date signed 9/8/47

X

G54979

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G54979 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: President Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1522 W. Lafayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles A. Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	M

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6 - 1885

8. AGE: Years	Months	Days	If less than one day
62	8	2	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Jobber

11. Industry or business

FATHER
12. Name Peter Davis
13. Birthplace Md

MOTHER
14. Maiden Name Jennie Snowden
15. Birthplace Md

16 (a) Informant Harrison C. Davis
(b) Address 303 W. 137th St. N.Y. City

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 9-10-47 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location A. A. Co.

18 (a) Funeral director Samuel M. Sulkanyd
(b) Address 1011 N. Arlington Ave

19 SEP 9 1947 (Date rec'd by registrar) (Signature) Hunting for Williams, M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8 1947, at 12 15 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-5-47 at 3:20 16/2 P M.
(b) Where did injury occur? Rear Ave. & Stricker St.
(c) Did injury occur at home, on farm, industrial place, in public place? On Truck While at work? yes
(d) Means of injury Fell to body of truck & Jumped to

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 9-8-47

G54980

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G54980

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 North Carey St.
(c) Hospital or institution: Good Samaritan Home for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2549 Madison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Maynard Lem Kettles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Sadie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 21, 1886

8. AGE: Years 61 | Months 6 | Days 13 | If less than one day hr. min.

9. Birthplace Hampton, Va (Town, county, and State)

10. Usual Occupation Chief Steward

11. Industry or business U. S. Maritime Service

FATHER
12. Name Thaddeus Kettle
13. Birthplace Hampton, Va

MOTHER
14. Maiden Name Annie ??
15. Birthplace Hampton, Va

16 (a) Informant Lafayette A. Cooper
(b) Address 2549 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 9, 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Lee H. Holland
(b) Address 1631 Druid Hill Ave

19 (a) SEP 9 1947 (Date received by registrar) (b) Huntington Williamsville, Md. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6, 1947 at 10:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 24 1947 to Sept. 5 1947, and that I last saw h[illegible] alive on Sept. 5 1947.

Immediate cause of death	Duration
Congestive heart failure	2 wks.
Due to Hypertensive Cardio vascular disease	yrs.
Due to	
Other Conditions Old Pectoral Hemiplegia	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Lamascolo M. D.
Address 960 W. Lombard Date signed

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C54981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered C54981

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital 6-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 89 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6 N. Ann St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Charles Bosak

3 (b) If veteran, name war: WW 2

3 (c) Social Security Account No. 212-09-9565

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Clara Bosak
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Jan. 24, 1912

8. AGE: Years	Months	Days	If less than one day
35	7	16	....hr. ....min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Paper cutter
11. Industry or business --

FATHER
12. Name Frank Bosak
13. Birthplace Austria

MOTHER
14. Maiden Name Helen Bostry
15. Birthplace Austria

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Cremation Hill Rd.

18 (a) Funeral director M. W. E. Doppel's Sons
(b) Address Lombard & Ann Sts.

19 (a) Date rec'd SEP 9 1947 (b) Registrar Huntington Williams, M.D.

V S 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9 1947, at 9:40A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 12 19 47, to Sept. 9 19 47, and that I last saw h. 1m alive on Sept. 9 19 47.

Immediate cause of death: Carcinoma of sigmoid colon with generalized abdominal metastases — Duration: 15 mos.

Due to — Duration:

Due to — Duration:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M.D.
Address Clinical Director Date signed 9/9/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54982

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G54982

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) just arrived

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County St. Mary's
(c) City or town SCOTLAND
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country no

3 (a) FULL NAME LUKE BARNES

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	B	M

6 (b) Name of husband or wife Sophie Rustine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 28 1889

8. AGE: Years	Months	Days	If less than one day
57 58	11	10,11	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation farmer
11. Industry or business

FATHER
12. Name major Barnes
13. Birthplace MD.

MOTHER
14. Maiden Name Sophie Rustine
15. Birthplace Maryland

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof 9-12-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Leonardtown, Maryland

18 (a) Funeral director Pius E. Robinson
(b) Address Dameron, Maryland.

19 (Date received by Registrar) SEP 9 1947 (Signature of Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 1947 at 7.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 1947 to 19 ; and that I last saw h alive on Sept 9 1947.

Immediate cause of death Bronchial Hemorrhage probably due to — Duration today

Due to Generalized Arteriosclerosis — chronic

Due to

Other Conditions Thrombo-Angiitis Obliterans
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Brickner
Address Mercy Hosp Date signed 9-9-47 M. D.

VS 150

G54983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G54983

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Dot
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2024 N. Charles St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELLA T. LAWLOR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	-S-

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years	Months	Days	If less than one day
73 72			hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name James Lawlor
13. Birthplace Ireland

MOTHER
14. Maiden Name Winifred Zwicke
15. Birthplace Ireland

16 (a) Informant Mary L. Lawlor
(b) Address 2024 N. Charles Street

17 (a) -B- (b) Date thereof 9-10-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location CITY

18 (a) Funeral director WIEDEFELD & SON
(b) Address GREENMOUNT AVE & 22ND

19 (a) SEP 9 1947 (b)
(Date rec'd by registrar) Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/7 19 47 at 8:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis
Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 9/9/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54984

433373

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

47 c

Registered No. G54984

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Cockeysville, (If outside city or town limits, write RURAL and give town)
(d) Street No. Boxwood, Farm. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John A. Healey.,

3 (b) If veteran, name war —

3 (c) Social Security Account No. 402-01-4251

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Virginia Healey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 6-2-04

8. AGE: Years	Months	Days	If less than one day
43	3	5	hr. min.

9. Birthplace New York (town, county, and state)
10. Usual Occupation Horse trainer
11. Industry or business

FATHER 12. Name Thomas J. Healey
13. Birthplace N.Y.

MOTHER 14. Maiden Name Margaret McLaughlin
15. Birthplace N.Y.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 10, 1947 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Henry W. Jenkins & Sons
(b) Address N. Eutaw & Orchard Sts

19 SEP 9 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7 1947 at 11 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1- 1947 to 9-7 1947 and that I last saw h[illegible] alive on 9-3 1947.

Immediate cause of death	Duration
Fractured intra Cranial	
Due to Cerebellar metastasis	
Due to Pulmonary metastasis	
Other conditions (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible] M. D.
Address [illegible] Date signed [illegible]

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

Registered No. G54985

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital 2-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 157 days
(e) Length of stay in Baltimore (yrs., mos., or days) unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 806 S Broadway, Balto, Md.
(If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country Argentina

3 (a) FULL NAME Lonich, Antonio

3 (b) If veteran, name war

3 (c) Social Security Account No. 130-14-0501

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Cvita Lonich
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19, 1900

8. AGE: Years	Months	Days	If less than one day
47	3	18	hr. min.

9. Birthplace Jugoslavia (Town, county, and state)
10. Usual Occupation seafarer
11. Industry or business

FATHER
12. Name Bare Lonich
13. Birthplace unknown

MOTHER
14. Maiden Name Steine Klipon
15. Birthplace unknown

16 (a) Informant Records
(b) Address U. S. Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 11 47 (month) (day) (year)
(c) Cemetery or crematory St. Matthi
Location O'Donnell, Lt

18 (a) Funeral director Sills & Zeller Inc
(b) Address 403 S. Wolfe, Jp.

19 (a) (Date rec'd by registrar) (b) Huntington Wills Registrar

SEP 9 1947

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 6, 1947, at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 2 1947 to Sept. 6 1947, and that I last saw h im alive on Sept. 6 1947

Immediate cause of death Carcinoma, left kidney (resected July 1946) with metastases to liver, lungs Duo- and spleen — Duration: Approx. 18 mos

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Russell Mitchell
J. Russell Mitchell, SA Surgeon
Address U. S. Marine Hospital Date signed 9/8/47 M. D.

X

G54986

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G54986
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 721 W. Lexington St.
(c) Hospital or institution: 4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 721 W Lexington St.
(Or give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrius Kutkeris

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-03-0314

4. Sex M. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Marcella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-15-1884

8. AGE: Years 63 | Months 8 | Days 6 | If less than one day hr. min.

9. Birthplace Lithuania
(Town, county, and state)

10. Usual Occupation TAILOR

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Helen Daskeviczius
(b) Address H.

17 (a) Burial (b) Date thereof 9-9-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Charles H Gaetano & Son
(b) Address 703 McHenry St

19 (a) SEP 9 1947 Huntington Williams M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5 1947, at 8:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 24 1946 to Sept 5 1947 and that I last saw him alive on Aug 30 1947

Immediate cause of death Coronary thrombosis

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter Sigmund M. D.
Address 1429 W. Fayette Date signed 9/8/47

VS 150

X

G54987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G54987

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hampstead Ave
(c) Hospital or institution: Pine Ridge Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 8

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2038 Myra St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George W. Meyer

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-07-7944

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Emma A. Rinky

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1870

8. AGE: Years 77 | Months 2 | Days 14 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Car-Maker

11. Industry or business

FATHER
12. Name John W. Meyer
13. Birthplace Md.

MOTHER
14. Maiden Name Not Known
15. Birthplace

16 (a) Informant Geo. W. Meyer
(b) Address 1716 W. Washington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/10/47 (month) (day) (year)
(c) Cemetery or crematory Balto.
Location Balto. Md.

18 (a) Funeral director Ed. Fanning & Son
(b) Address 1938 E. Lafayette Ave

19 (a) SEP 9 1947 (Date rec'd by registrar) (b) Huntington Williamson, M.D. Address

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6 1947 at 11:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1 1947 to Sep 6 1947 and that I last saw h[illegible] alive on Sept 1 1947

Immediate cause of death	Duration
Uremia	
Due to Hardened arteries	
Due to Ca of Prostate	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Conrad R. Rinker
Address 706 N. Wash. St Date signed 9/8/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G54988

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7909 Elmhurst Ave.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Goetz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Elizabeth
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) 4-2-1896

8. AGE: Years	Months	Days	If less than one day
51	6	6	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Supt. Drydock
11. Industry or business Industry

FATHER
12. Name Albert Goetz
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace Germany

16 (a) Informant Mrs. Elizabeth Goetz
(b) Address 7909 Elmhurst

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-10-47 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Balto

18 (a) Funeral director Leonard J. Luck
(b) Address 5305 Harford Road

19 (a) [illegible] 1947 Huntington Williams, M.D.
(Signature of registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-8 1947, at 8:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-6-8-8-1947 to 8-5-6-9-8-1947, and that I last saw h[illegible] alive on 9-8 1947.

Immediate cause of death (a) Coronary Occlusion — Duration 3 days

Due to Hypertension — 2 yr

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William A. Goetz M. D.
Address Mercy Hosp. Date signed 9-8-47

G54989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓61

Registered No. G54989

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3811 St. Paul St.
(c) Hospital or institution: none 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2406 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy Pennix (Wood)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: divorced

6 (b) Name of husband or wife Clarence Woods

6 (c) If alive, give age about 53 years

7. Birth date of deceased (mo., day, yr.) May 15, 1895 (?)

8. AGE: Years 52 | Months 3 | Days 23 | If less than one day ... hr. ... min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name Nelson Pennix
13. Birthplace N.C.

MOTHER
14. Maiden Name Sarah Pennix
15. Birthplace N.C.

16 (a) Informant Bessie E. Dirs
(b) Address 236 W. 135 St. N.Y. City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 11 '47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Annapolis Road. Mt. Winans

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place

19 SEP 10 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-8- 1947, at 8 15 A.M

21. I certify that I took charge of the remains described above, held an Autopsy + Insp. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 9-8-47

93

G54990 R. Blake BCH B02435

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓107

G54990
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1220 Aisquith St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) life
(e) Length of stay in Baltimore (yrs., mos., or days) 10

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1220 Aisquith St (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME David K. Fields. Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Col.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1944

8. AGE: Years 3 | Months 3 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name David K. Fields

13. Birthplace D.C.

MOTHER 14. Maiden Name Florence Foster

15. Birthplace Norfolk, Va.

16 (a) Informant David K. Fields

(b) Address 1220 Aisquith St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-10-47 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location Balto. County, Md.

18 (c) Funeral director Joseph B. Hebb Jr.

(b) Address 1330 N. Eutaw St.

SEP 10 1947 (Date rec'd by Registrar) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 8 1947 6:A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1-1947 to 9-8-1947 and that I last saw h alive on 9-8-1947.

Immediate cause of death Bronchio-Pneumonia — Duration 10 days

Due to Colds & Exposure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. R. Blake M.D.

Address 1327 N. Eutaw St. Date signed Sept. 10 1947

X

G54991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G54991

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2644 Maryland avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 78 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2644 Maryland avenue
(If no street, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE A. MORSE

3 (b) If veteran, name war --

3 (c) Social Security Account No. ----

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Robert E. Morse

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25, 1868

8. AGE: Years 79 | Months 3 | Days 14 | If less than one day ... hr. ... min.

9. Birthplace West Virginia
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name John Dougherty
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Burns
15. Birthplace Ireland

16 (a) Informant Mrs. Herbert Abele
(b) Address 2644 Maryland avenue

17 (a) Burial (b) Date thereof 9/11/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Grass & Son Inc
(b) Address 118 N. Mt. Royal Ave

19 (a) SEP 10 1947 (Date of this burial) (b) Huntington, W. Virginia (Register)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 25 1947 to Sept. 9 1947, and that I last saw her alive on Sept. 8, 1947

Immediate cause of death	Duration
Cerebral Hemorrhage	36 hrs
Due to Arteriosclerosis	2
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George H. Grass.

Address 28 W. 25th St Date signed 9/10/47

VS 150

X

G54992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G54992
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 804 Washington Blvd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 804 Washington Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VINCENT FARACE

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-12-6156

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Catherine

6 (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) Nov. 18 1898

8. AGE: Years 48 | Months 9 | Days 21 | If less than one day ____hr. ____min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Trucker, Hand

11. Industry or business

FATHER
12. Name Joseph Farace
13. Birthplace Italy

MOTHER
14. Maiden Name Marie Farace
15. Birthplace Italy

16 (a) Informant Mrs Catherine Farace
(b) Address 804 Washington Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 13 1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Old Frederick Road

18 (a) Funeral director Joseph Farace Inc.
(b) Address 2013 Monument Ave.

19 SEP 10 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9, 1947, at 10 a.M.

21. I certify that I took charge of the remains described above, held an insp. & inq. thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hypertensive cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 9-9-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G54993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G54993 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 E. 23rd st
(c) Hospital or institution: Beck Diagnostic Clinic
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 141 E. Monument ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Loretta W. Adams.

3 (b) If veteran, name war —

3 (c) Social Security Account No. no

4. Sex f. | 5. Color or race W. | 6 (a) ~~Single, married~~, widowed or divorced

6 (b) Name of husband or wife James M. Adams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26, 1891

8. AGE: Years	Months	Days	If less than one day
56	4	13	hr. min.

9. Birthplace Phillippi, W. Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Wolfe
13. Birthplace Virginia

MOTHER
14. Maiden Name A. Timble
15. Birthplace Phillippi, W. Va.

16 (a) Informant Mr. Douglas Moorehead
(b) Address Essex, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11.47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

SEP 10 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1947 to Sept 9 1947 and that I last saw h. alive on Sept 8 1947

Immediate cause of death — Duration
Clip. Myocarditis — 3d.
Decompensated
Due to a. Hypostatic Pneumonia
Other Conditions Hypostatic Pneumonia — 3 days

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at — M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Nathaniel M Beck M. D.
Address 100 E. 23rd st Date signed

G54994

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13P

G54994 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1116 E. 36th St.
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1116 E. 36th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH NETTER

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife: Margaret Ellen Netter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/3/1889

8. AGE: Years	Months	Days	If less than one day
58	1	6	hr. min.

9. Birthplace: Goshen, Ind. (Town, county, and state)
10. Usual Occupation: Retail Meat Merchant
11. Industry or business: Self

FATHER
12. Name: Benjamin Netter
13. Birthplace: France

MOTHER
14. Maiden Name: Clara Bernstein
15. Birthplace: Germany

16 (a) Informant: Mrs. Margaret Netter, wife
(b) Address: 1116 E. 36th St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/10/47 (month) (day) (year)
(c) Cemetery or crematory: Maplewood Cem.
Location: Anderson, Ind.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date received by registrar) (b) Registrar: Huntington Williams M. D.

SEP 10 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9, 1947, at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12 August 1947 to 9 Sept 1947, and that I last saw h[illegible] alive on 9 Sept 1947.

Immediate cause of death	Duration
Chron. Pulmonary Fibroid Tuberculosis.	6 mos +
Due to ✓	
Due to ✓	
Other Conditions ✓	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. Bruce Hooper M. D.
Address 3534 Ellerslie Ave Date signed 9/10/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

G54995

Registered No. G54995

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4505 Roland Ave
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4505 Roland Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Francis Clement Dorsey

3 (b) If veteran, name war: 1st

3 (c) Social Security Account No. 212-12-9455

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Laura W. Dorsey

6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Oct. 31 1876

8. AGE: Years 70 | Months 11 | Days 9 | If less than one day: hr. min.

9. Birthplace Cecil Co. Md. (Town, county, and state)

10. Usual Occupation Mechanical Engineer

11. Industry or business

FATHER
12. Name Patrick Dorsey
13. Birthplace Ireland

MOTHER
14. Maiden Name Honora
15. Birthplace Ireland

16 (a) Informant Mrs Laura W. Dorsey (wife)
(b) Address 4505 Roland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 12 47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto. Md.

18 (a) Funeral director Stewart Morris Co.
(b) Address 108 W. Preston

19 (a) (To be filled in by registrar) (b) Registrar

SEP 10 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 1947, at 12-57 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1944 to Sept 9 1947, and that I last saw h[illegible] alive on Sept 9 1947.

Immediate cause of death Myocardial
Coronary Thrombosis
Due to Arteriosclerosis

Due to Carcinoma of
esophagus

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation Resection esophagus
Major findings of operation: May 1944
Pulmonary
of autopsy Resection Adenocarcinoma

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature H. M. Smith M. D.
Address 342 Charles St. Date signed 9/8/47

X

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54996 BALTIMORE CITY HEALTH DEPARTMENT G54996

CERTIFICATE OF DEATH ✓ 186a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3422 Guilford Terrace
(c) Hospital or institution: home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 17
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3422 Guilford Terrace
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Mary Correy Huggins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife None

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 23 - 1862

8. AGE: Years	Months	Days	If less than one day
85	1	15	hr. min.

9. Birthplace Balto. - md.
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business " "

FATHER
12. Name Thomas J. Huggins
13. Birthplace Liberty - Missouri

MOTHER
14. Maiden Name Jane Eliza Magraw
15. Birthplace ? - Cumberland - Md.

16 (a) Informant Miss Annie C. Huggins (sister)
(b) Address 3422 Guilford Terrace City

17 (a) Burial (b) Date thereof 9 - 11 - 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore City

18 (a) Funeral director STEWART & MOWEN COMPANY
(H. F. Mowen Sec.) 100 W. North Avenue
(b) Address

(a) (b) for Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8 1947, at 8 P. M

21. I certify that death occurred on the date above stated, and attended deceased from Sept 8 1947 to Sept 8 1947
and that I last saw her alive on Sept 7 1947

Immediate cause of death: Myocardial Insuff. — Duration: 3 days

Due to

Due to — Duration: own

Other Conditions Fracture R. Hip — Duration: 10 weeks
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Adam E. Wilson, M.D.
Address 32 W. Biddle Date signed 9-9-47

G54997 — BALTIMORE CITY HEALTH DEPARTMENT — CERTIFICATE OF DEATH ✓ 93D — G54997

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4724 Park Heights Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7-16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4724 Park Heights Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Wade

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Harry J. Wade,
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13 (1867) 1877

8. AGE: Years 70 (80) | Months 7 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business at home

FATHER
12. Name Frank Wilmering,
13. Birthplace Germany,

MOTHER
14. Maiden Name Anna Tuschan,
15. Birthplace Germany,

16 (a) Informant Mr. Harry J. Wade,
(b) Address 4724 Park Heights Ave.,

17 (a) Burial (b) Date thereof 9/11/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer,
Location Baltimore City,

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

SEP 10 1947
(Date rec'd by registrar) (b)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8, 1947 19 , at 3.45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/2 19 47 to 9/8/ 19 47 and that I last saw h er alive on 9 / 8 19 47

Immediate cause of death

Acute Gastro Enteritis Cardio Vasc Disease — Duration 24 hrs.

Due to Cerebral Thrombosis — Duration one to two days

Due to — Duration

Other Conditions Hypostatic Pneumonia — Duration 6 days one day

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alex A Wanstocke M. D.
Address 4603 Park Heights Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 458

G54998 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2228 Callow Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2228 Callow Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris M Silberstein

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jennie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 79 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name Samuel Silberstein
13. Birthplace Russia

MOTHER
14. Maiden Name Annie ?
15. Birthplace Russia

16 (a) Informant Samuel M Silberstein
(b) Address 3706 Egerton Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept, 11, 1947 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh Cemetery
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

SEP 10 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION 6.20

20. DATE OF DEATH September 9 1947, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1946 to Sept 7 1947 and that I last saw h. m. alive on Sept 9 1947

Immediate cause of death: Carcinoma of tongue with metastases — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Irwin Jaffe M.D.
Address 3003 Garrison Blvd Date signed Sept 9 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G54999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G54999 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lennings Lane
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore -Chesacoa Park
(If outside city or town limits, write RURAL and give town)
(d) Street No. Shirley Tourist Camp.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: FRED TOBOLL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Irene M. Toboll

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 4th, 1903

8. AGE: Years 44 | Months 1 | Days 5 | If less than one day ....hr. ....min.

9. Birthplace: Baltimore County, Md.
(Town, county, and state)

10. Usual Occupation: Electrician

11. Industry or business: Glenn L. Martin Co.

FATHER
12. Name: John F. Toboll
13. Birthplace: Germany

MOTHER
14. Maiden Name: Minnie Klosterman
15. Birthplace: Germany

16 (a) Informant: Mrs. F.C. Toboll
(b) Address: 2037 E. Hoffman St.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 9/12/47 (month) (day) (year)
(c) Cemetery or crematory: Zion Lutheran
Location: Stemmers Run

18 (a) Funeral director: Lasseter Funeral Home
(b) Address: 7401 Belair Rd.

9-10-1947 (Date received by registrar) Huntington Williams Jr.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8, 1947, at 11.25 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, Spontaneous

Due to

Other Conditions Fatty Degeneration of Liver

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ....at ....M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner
Date signed 9-9-47

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55000 Londeman G55000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 531 E. Gittings St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 531 E. Gittings St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amelia H. Londeman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced W.

6 (b) Name of husband or wife Louis C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/20/1896

8. AGE: Years 51 | Months 6 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Wm. Borkman
13. Birthplace Ger.

MOTHER
14. Maiden Name Bertha Ruf
15. Birthplace Ger.

16 (a) Informant Family
(b) Address 531 E. Gittings St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 9-12-47 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Green Mount Cem.

18 (a) Funeral director Jenny Lee Long
(b) Address 120 E. Hoffman

19 (a) 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8 1947, at 1 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1946 to Sept. 8 1947, and that I last saw him alive on Aug 25 1947.

Immediate cause of death: Acute Coronary occlusion — Duration 1 hr
Due to Coronary Sclerosis — 6 yrs
Due to Hypertension & Cardiovascular Renal Disease — 6 yrs
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Walter Cohn
Address 1020 Fort Ave Date signed 9/10/47

X

G55001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G55001 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Md.
(b) Street address 1301 W. Clarkson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1301 Clarkson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME Paul H. Carel Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Married

6 (b) Name of husband or wife Ella A. Carter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/22/1892

8. AGE: Years	Months	Days	If less than one day
54	10	16	hr. min.

9. Birthplace Steel Jersey
(State or country)

10. Usual Occupation Stockkeeper

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Katherine Rhea
15. Birthplace Balto.

16 (a) Informant Family
(b) Address 1301 Clarkson St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 9-12-47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Beech Grove

18 (a) Funeral director James H. McCurdy
(b) Address 130 E. Lanvale
(Huntington Williams, M.D.)

19 (a) 1947 (b) Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8, 1947, at 8.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/5/1939, to 9/8/1947, and that I last saw him alive on 9/7/1947.

Immediate cause of death	Duration
Coronary thrombosis	
associated with hypertensive	5 yrs.
Due to cardio vascular disease.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Deitel M. D.

Address 1226 Hanover St. Date signed 9/10/1947

X

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G55002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

G55002 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1714 E. Fayette St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 3
(e) Length of stay in Baltimore (yrs., mos., or days) 47yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1714 E. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Najib Tooma

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-05-9549

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Married

6 (b) Name of husband or wife Catherine Tooma
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12 1879

8. AGE: Years	Months	Days	If less than one day
68	3	27	hr. min.

9. Birthplace Egypt (City, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name — Tooma
13. Birthplace Egypt

MOTHER
14. Maiden Name
15. Birthplace Egypt

16 (a) Informant Mrs. Victoria Lamandjie
(b) Address 710 N. Lakewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 12 47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Philip Herring Sons
(b) Address 2024 Orleans St

19 (a) 19[illegible] (b) (Filed by registrar)

Registrar Huntington Williams

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8 1947, at 1 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 1947 to Sept 8 1947, and that I last saw him alive on Sept 7 1947

Important cause of death	Duration
Coronary occlusion	about
Due to Coronary Heart Disease	5 hrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isaac A. Lamb M. D.
Address 700 E. Baltimore Date signed 9/10/47

G55003 G55003

BALTIMORE CITY HEALTH DEPARTMENT

BC# 4288526 CERTIFICATE OF DEATH 159 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 5226 Beauford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/9/47

8. AGE: Years	Months	Days	If less than one day
			One hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John F. Dell
13. Birthplace Md.

MOTHER
14. Maiden Name Anne Adams
15. Birthplace Balto., Md.

16 (a) Informant John F. Dell
(b) Address 5226 Beauford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 11 '47 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location

18 (a) Funeral director Wheatley & Donovan
(b) Address 3615-17 Pennsylvania Ave. Huntington for Williams, Md

19 (a) 10 1947 (rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2, 1947, at 11.47 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19

Immediate cause of death Atelectasis, prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D.
Address Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G55004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V94a

G55004 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3917 Keswick Road.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3917 Keswick Road. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME E.Arthur Newman.

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Pearl M. Newman.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 10,1880

8. AGE: Years	Months	Days	If less than one day
67	6	27	hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Optometriat.
11. Industry or business

FATHER
12. Name Holiday Newman.
13. Birthplace Pa.

MOTHER
14. Maiden Name Julia Wentworth.
15. Birthplace Pa.

16 (a) Informant Mrs.Pearl M. Newman.
(b) Address 3917 Keswick Road.

17 (a) Entombment (b) Date thereof Sept 12/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Mausoleum
Location Windsor Mill Road.

18 (a) Funeral director Chenoweth & Donovan.
(b) Address 3615 17 Chestnut Ave.

SEP 10 1947 (b)
(Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9, 1947, at 4.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 6 1947 to Sept. 9 1947. and that I last saw him alive on Sept 9 1947

Immediate cause of death: Coronary Thrombosis — Duration: 1 day
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J H Wilson M. D.
Address 617 W. 40th St Date signed 9/10/47

G55005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G55005
Registered No.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 313 S. High St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank J. Wilchinsky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4, 1906

8. AGE: Years	Months	Days	If less than one day
41 42	5	5 4	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Wilchinsky
13. Birthplace Lithuania

MOTHER
14. Maiden Name Agnes
15. Birthplace Lithuania

16 (a) Informant Anna Lutz
(b) Address Green Haven, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 11, 1947 (month) (day) (year)

(c) Cemetery ~~Greenmount~~ X Holy Redeemer
Location Belair Rd. Baltimore, Md.

18 (a) Funeral director Frank Della Noce
(b) Address 52 N. Morley Street.

19 (a) SEP 10 1947 (b) Huntington Woodlawn, Md.
(Date rec'd by registrar) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8th 1947, at 7-20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Edema

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil C. Rogy M.D.
Medical Examiner.
Date signed 9-9-47

G55006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (301)

G55006 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp. 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore St. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3044 N. Gilmore St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Duppins

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-03-0344.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife. Elizabeth Duppins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 12, 1930

8. AGE: Years 26 | Months 11 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Steel Worker.

11. Industry or business

FATHER 12. Name Harry H. Duppins.
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Isabella Henderson
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Elizabeth Duppins
(b) Address 3044 N. Gilmore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-11-1947. (month) (day) (year)
(c) Cemetery or crematory Balto National
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

SEP 10 1947 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7, 1947, at 12:30 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Ruptured aneurysm of abdominal aorta.

Due to Massive abdominal hemorrhage

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George E. Merrill M.D. Medical Examiner.
Date signed 9-8-47

VS 191

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G55007 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A.
(b) Street address 513 Dolphin St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 513 Dolphin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daisy Kelly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife Archie Kelly
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1896

8. AGE: Years	Months	Days	If less than one day
50	10	1	hr. min.

9. Birthplace Richmond, Virginia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Preston Johnson
13. Birthplace Richmond, Virginia

MOTHER
14. Maiden Name Leanora Robinson
15. Birthplace Richmond, Virginia

16 (a) Informant Mrs. Archie Kelly
(b) Address 513 Dolphin St

17 (a) Burial (b) Date thereof 9-11-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Zion
Location

18 (a) Funeral director Mrs. Katie R. Willis
(b) Address 322 N. Schroeder St,

(a) SEP 10 1947 (b)
(Date received by registrar) Huntington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/7 1947 at 7 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 9/10/47

G55008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G55008 Registered No. 121

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 1135 N. Gilmor St
(a) Baltimore City, Maryland Balto, Md.
(b) Street address 1135 N. Gilmor St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1135 N. Gilmor
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Henderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 4, 1909

8. AGE: Years	Months	Days	If less than one day
38	6	2	hr. min.

9. Birthplace Henderson, N. C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Henderson
13. Birthplace Henderson, N. C.

MOTHER
14. Maiden Name Elizabeth Readis
15. Birthplace Henderson, N. C.

16 (a) Informant Mable Fountain
(b) Address 1135 N. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-11-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Wilkins
(b) Address 2222 W. Baltimore St

19 9 0 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6 1947, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/29/1947 to 9/6/1947 and that I last saw h— alive on 9/6/1947.

Immediate cause of death Acute Appendicitis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature W. D. Taylor
Address 1822 Harlem Ave (Date signed) 9/8/47

VS 150

G55009

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G55009 Registered No.

MARGIN RESERVED FOR BINDING

"PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1070 W Fairmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d
(e) Length of stay in Baltimore (yrs., mos., or days) 51 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1070 W Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Wooden

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: James A Wooden

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26 - 96

8. AGE: Years 51 | Months 1 | Days 11 | If less than one day: hr. min.

9. Birthplace Balto md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name William Smith

13. Birthplace Balto

MOTHER 14. Maiden Name Ella Jane Smith

15. Birthplace Md.

16 (a) Informant Mrs. James Wooden.

(b) Address 1070 W. Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-10-1947 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Mrs. Katie R. Wilkins

(b) Address 222 N. Schroeder St.

19 (a) (b) Registrar

(Date received by registrar) SEP 10 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/6 1947, at 3:05 a M

21. I certify that death occurred on the date above stated, that I attended deceased from 7/1 1947 to 9/6 1947, and that I last saw h[illegible] alive on 9/6 1947.

	Duration
Immediate cause of death Cardio-Renal Disease, Hypertension	1 yr
Due to Old age	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. A. Jaspon

Address Coon Auburn Date signed 9/6/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 823a

G55010

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Attrd, Baltimore 29, Md
(c) Hospital or institution:
The Sudy Sanitarium
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Attrd Baltimore 29 Md
(If rural give location)
(e) If foreign born, how long in U. S. A.? years.

3 (a) FULL NAME Susan Paine Hiosh (Susan Paine Hiook)

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	white	Divorced

6 (b) Name of husband or wife Edmund M. Hiosh
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-20-1878

8. AGE: Years	Months	Days	If less than one day
68	11	19	hr. min.

9. Birthplace Saginaw, Mich.
(Town, county, and state)
10. Usual Occupation ~~housewife~~ None
11. Industry or business

FATHER
12. Name A. B. Paine
13. Birthplace New York

MOTHER
14. Maiden Name Jennie Frazer
15. Birthplace Mich.

16 (a) Informant Harriett Hiosh (daughter)
(b) Address John Hopkins Hospital

17 (a) Cremation (b) Date thereof Sept 11-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Penna Ave Baltimore, Md

19 (a) (b) Registrar
(Date rec'd by registrar)

SEP 10 1947

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH September 9 1947, at 5 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from September 1934, to September 1947, and that I last saw h[illegible] alive on Sept 8 1947.

Immediate cause of death Cerebral hemorrhage — Duration 1 day

Due to hypertension — 10 yrs

Due to arteriosclerosis — yrs

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rachel (Gundry) Tickner M. D.
Address 500 E. Fredrick Rd. Date signed 9-9-47

G55011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

111a

G55011
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Dennison Street
(c) Hospital or institution:
Crawford Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1.1/2 Yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5501 Park Heights Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Mae (Bilson) Rose

3 (b) If veteran, name war: 686

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	W.

6 (b) Name of husband or wife: Thomas Rose
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1887

8. AGE: Years	Months	Days	If less than one day
60	3	24	hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Nurse
11. Industry or business: (Crawford) Nursing Home

FATHER
12. Name: Harry P. Bilson
13. Birthplace: Harpers Ferry, W. Va.

MOTHER
14. Maiden Name: Laura. V. Norris
15. Birthplace: Harpers Ferry, W. Va.

16 (a) Informant: Mr. Harry Bilson
(b) Address: 3015 Spaulding Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/47 (month) (day) (year)
(c) Cemetery or crematory: London Park
Location: Baltimore, Maryland

18 (a) Funeral director: LORING BYERS
(b) Address: 5005 Park Heights Ave

SEP 10 1947
(Date filed by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8, 1947, at 6P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1947 to Sept 8 1947 and that I last saw h[illegible] alive on Sept 8 1947.

Immediate cause of death: Pulmonary Tuberculosis — Duration: 2 years

Due to: Arteriosclerosis & Premature senility — Duration: several years

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 3033 W Lanvale St Date signed 9/10/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G55012
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3605 Hillsdale Road
(c) Hospital or institution:
Anderson Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3810 Woodbine Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Theodore Stansbury

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Katie Stansbury

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1861

8. AGE: Years 86 | Months 2 | Days 6 | If less than one day hr. min.

9. Birthplace Carroll County, Md.
(Town, county, and state)

10. Usual Occupation Retired Carpenter

11. Industry or business

FATHER
12. Name Oliver Stansbury
13. Birthplace Carroll County, Md.

MOTHER
14. Maiden Name Isabelle Hare
15. Birthplace Carroll County, Md.

16 (a) Informant Mr. Russell C. Hosfeld
(b) Address 3810 Woodbine Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 11 1947 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cemetery
Location Pikesville, Md.

18 (a) Funeral director Miller & Amoroso

(b) Address 4510 Liberty Heights Ave.

19 (a) (b) Date received by Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 9 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/16 1947 to 9/8 1947 and that I last saw h alive on 9/8 1947

Immediate cause of death: Duration
Cerebro sclerosis 10 yrs
cerebral hemorrhage
Due to hypertension & fatty 14 days
Myocarditis degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Russell M. D.

Address 3902 Groveland Ave. Date signed 9/10/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55013 CM. 113227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V124 B

Registered No. G55013

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE.
(c) Hospital or institution: Baltimore City Hospitals 26-12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 18 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No Address (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fred, Siebert

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Div.

6 (b) Name of husband or wife: Annie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20 -1888

8. AGE: Years 59 | Months 1 | Days 19 | If less than one day 20 hr. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frederick John Siebert
13. Birthplace Germany

MOTHER
14. Maiden Name Lillian Young
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 9/13/47 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Md
Location Baltimore Md

18 (a) Funeral director Tilford Con Co
(b) Address 1947 W Pratt St

19 (a) SEP 11 1947 (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9 - 1947, at 3.55P M

21. I certify that death occurred on the date above stated; that I attended deceased from July - 21 1947 to Sept. 9 1947 and that I last saw him alive on Sept. 9 - 1947.

	Duration
Immediate cause of death Cardiac failure.	
Due to Hypertensive Cardiovascular Disease -	
Due to Portal Cirrhosis Portal thrombosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Splenomegaly

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard T. Bunford M. D.
Address Balt City Hosp Date signed 9-10-

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55014 113529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G55014

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days.
(e) Length of stay in Baltimore (yrs., mos., or days) life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1422 N. Gay St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME Lizzie Reiser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-26-73

8. AGE: Years 74 | Months 4 5 | Days 14 15 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Reiser (D)
13. Birthplace Bavaria

MOTHER
14. Maiden Name Barbara Getz (D)
15. Birthplace Bavaria

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Wilson Conway
(b) Address 1217 N. Gay St

19 SEP 11 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-10- 1947 3:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-3- 1947 to 9-10- 1947, and that I last saw h[er] alive on 9-10 1947.

Immediate cause of death: Cardiac failure — Duration

Due to: Arteriosclerotic Cardiovascular Disease

Due to:

Other Conditions: Carcinoma of breast + Malnutrition
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard T. Barford. M. D.
Address Balt. City Hosp. Date signed 9-10-47

927

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No. G55015

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 64 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 Division St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Phillip Francis Carrington

3 (b) If veteran, name war: WWI
3 (c) Social Security Account No. --

4. Sex: M
5. Color or race: col
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 18, 1892

8. AGE: Years 55 | Months - | Days 23 | If less than one day hr. min.

9. Birthplace Norfolk, Va.
(Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name Nathaniel Carrington
13. Birthplace Va.

MOTHER
14. Maiden Name Betty ?
15. Birthplace Va.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (b) Date thereof 9-12-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) Sept. 1947 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10 1947, at 2:40A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 8 1947, to Sept. 10 1947, and that I last saw him alive on Sept. 10 1947.

	Duration
Immediate cause of death: Carcinoma of mid and lower 1/3 esophagus with metastases to liver,	
Due to: mediastinum and posterior thoracic wall	18 MOS.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 9/10/47

V S 150

G55016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G55016

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hospital 10-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1214 Aisquith Street. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME ARTHUR MILLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1923

8. AGE: Years	Months	Days	If less than one day
24			hr. min.

9. Birthplace Prince Edward Co., Va. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Arthuf Miller
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Miller
15. Birthplace Va.

16 (a) Informant Mary Miller
(b) Address RFD #1 Box 23 Rice, Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-13-47 (month) (day) (year)
(c) Cemetery or crematory.....
Location Farmville, Virginia

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) SEP 11 1947 (Date rec'd by registrar) (Signature) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9, 1947, at 11.30 a M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture of Skull
Intra Cranial Hemorrhage

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-7-47 at 3 p. M.
(b) Where did injury occur? 1214- Aisquith St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fell from roof.

23. Signature [signature] M.D. Medical Examiner.
Date signed 9-9-47

G55017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G55017 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 219 N Carlton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 219 N Carlton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William Wren

3 (b) If veteran, name war ✓

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	married

6 (b) Name of husband or wife Julia Wren
(c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) 11/30/1902

8. AGE: Years	Months	Days	If less than one day
44	9	8	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Robert Wren
13. Birthplace Va

MOTHER
14. Maiden Name Kate Williams
15. Birthplace Baltimore Md

16 (a) Informant Julia Wren
(b) Address 711 S Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 13 47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore Md

18 (a) Funeral director Sarah L Brown Son
(b) Address 1048 W Monty omery St

19 SEP 11 1947 Date rec'd by registrar Huntington Williams M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/8 1947, at 3P, M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/10 1946 to 9/8 1947, and that I last saw h[illegible] alive on 9/8 1947.

Immediate cause of death Pulmonary Tuberculosis

Duration
18 mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David Trauerman M. D.
Address 1111 Lee N Date signed 9/10/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G55018 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Catons & Wilkins Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ~~Baltimore~~ Howard
(c) City or town Ellicott City R.D. (If outside city or town limits, write RURAL and give town)
(d) Street No. Glenelg Md. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Myrtle Shipley
3 (b) If veteran, name war None
3 (c) Social Security Account No. None
4. Sex female
5. Color or race white
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Wyeham Shipley
6 (c) If alive, give age 69 years
7. Birth date of deceased (mo., day, yr.) June 25 1885
8. AGE: Years 62 | Months 2 | Days 15 | If less than one day ..... hr. ..... min.
9. Birthplace Glenelg, Md. (Ellicott City) (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph B Coombes
13. Birthplace Maryland

MOTHER
14. Maiden Name Anthie R. Burgess
15. Birthplace Maryland

16 (a) Informant Mrs. Cadton Kerger
(b) Address Ellicott City Maryland.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/12/47. (month) (day) (year)
(c) Cemetery or crematory St. John's Cemetery
Location Ellicott City, Maryland.
18 (a) Funeral director Easton & Sons
(b) Address Ellicott City, Maryland.
19 (a) SEP 11 1947 (Date rec'd by registrar) Clifton Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/9 1947, at 11:45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/16 1947 to 9/9 1947, and that I last saw h.e alive on 9/9 1947.

Immediate cause of death	Duration
Cerebral Vascular Accident	
Due to Massive Abdominal Wall Abscess Double Barrel Ileostomy	
Due to Gangrene of Mid Ileum Umbilical Hernia	
Other Conditions Strangulated	

(Include pregnancy within 3 months of death)

Date of operation 16 Aug 47
Major findings of operation: Strangulated Umbilical Hernia
of autopsy: Confirmed

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W E D. Grath M. D.
Address St. Agnes Hosp. Date signed 9 Sept 47

G55019 BCH F 19807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓56E

Registered No. G55019

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 - 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 359 Elmino St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Diane R. Fleischmann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/3/1943

8. AGE: Years	Months	Days	If less than one day
4	2	5	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Leonard H. Fleischman
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Harriette M. Lloyd
15. Birthplace Balto. Md.

16 (a) Informant Leonard H. Fleischman
(b) Address 359 Elmino St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 11-47 (month) (day) (year)
(c) Cemetery or crematory St. Matthews Lawn
Location Edmondson Ave.

18 (a) Funeral director John A. Miller
(b) Address 2334 Jefferson

19 (SEP 11 1947 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8 1947 at 9 15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7 1947 to Sept 8 1947, and that I last saw h[illegible] alive on Sept 8 1947

Immediate cause of death	Duration
Respiratory Failure	12 hrs.
Due to Bronchial obstruction	?
Due to Tumor of Bronchus	? over
Other Conditions Asthma	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Tumor of bronchus

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Helen M Ennis M.D.
Address Sinai Hosp Date signed 9/8/47

X

C55020 Blk B-82949

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1578

Registered No. C55020

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 139- S. Potomac Street.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 139 S. Potomac Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS E. SANDLES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5- 1947

8. AGE: Years | Months: 2 | Days: 4 | If less than one day: hr. min.

9. Birthplace: Balto
(Town, county, and state)

10. Usual Occupation

11. Industry or business: None

FATHER
12. Name: Louis Sandles
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: Louise Sauers
15. Birthplace: Balto

16 (a) Informant: Louise Sandles
(b) Address: 139 S Potomac St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 12 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn
Location: City

18 (a) Funeral director: Uelrich Funeral Home
(b) Address: 220 E Orleans St

19 SEP 11 1947 (Date rec'd by registrar) Huntington Williams, MD Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9, 1947, at 9.30 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Malnutrition

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George F. Merrill M.D.
Medical Examiner.
Date signed 9-9-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C55021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. C55021

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hampnett Ave.
(c) Hospital or institution:
Pine Ridge Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2320 Harlem Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD S. ANDERSON

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widower

6 (b) Name of husband or wife: Mary Etta Anderson (nee Griffith)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1866

8. AGE: Years	Months	Days	If less than one day
80	9	10	hr. min.

9. Birthplace Vienna, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Rufus Anderson
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Mary A. Jeffrey, daughter
(b) Address 2320 Harlem Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/47 (month) (day) (year)
(c) Cemetery or crematory Friendship Cem.
Location A. A. Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 SEP 11 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8, 1947, at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/7 1947, to 9-8 1947, and that I last saw h im alive on 9-8 1947.

Immediate cause of death	Duration
Hypertensive cardiovascular disease	
Due to Arteriosclerosis	
Due to	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Daniel J. Schwartz
Daniel J. Schwartz, M.D. M. D.
Address 2320 Eutaw Pl. Date signed 9-10-47

937

G55022 Alessi

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 B

Registered No. G55022

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6306 Harford Roau
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6306 Harford Roau (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Henry Hebbel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 21, 1875

8. AGE: Years	Months	Days	If less than one day
71	8	19	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation unemployed
11. Industry or business

FATHER
12. Name Christian Hebbel
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Stephens
15. Birthplace N.Y.

16 (a) Informant Mrs. Emma H. Spotten
(b) Address 6306 Harford Road, 14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 SEP 11 1947 Huntington Williams M.D. (Date rec'd by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9th, 1947 at 4.40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1947 to Sept 9 1947. and that I last saw h[illegible] alive on Sept 9 1947.

Immediate cause of death Carcinoma of the bladder — Duration Nov. 1946

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Alessi

Address 6212 Harford Rd Date signed 9/9/47

X

G55023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G55023

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4030 Boarman Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-10
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4030 Boarman Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Burkom

3 (b) If veteran, name war

3 (c) Social Security Account No.

Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Eva

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Barry
13. Birthplace Russia

MOTHER
14. Maiden Name Meyuse
15. Birthplace Russia

16 (a) Informant Leon Burkom
(b) Address 4030 Boarman ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-11-47 (month) (day) (year)

(c) Cemetery or crematory
Location Hebrew Herring Run

18 (a) Funeral director Jack Lewis Inc
(b) Address 2600 Eutaw Place

19 SEP 11 1947 (Date filed by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10th 1947, at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1942 to Sept 10th 1947, and that I last saw h[illegible] alive on Sept 10th 1947.

Immediate cause of death	Duration
Coronary thrombosis	
Due to Coronary sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. Hugh H. Bix M. D.
Address 2516 Linden Ave Date signed 9-10 47

G55024

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G55024

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 911 W. Lombard Street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 - 3
(e) Length of stay in Baltimore (yrs., mos., or days) -

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 911 W. Lombard Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna E. Prather

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Joseph H. Prather
6 (c) If alive, give age ~~19~~ 191 years

7. Birth date of deceased (mo., day, yr.) Aug. 14, (1861)

8. AGE: Years	Months	Days	If less than one day
58 (85)	0	28 ?7	hr. min.

9. Birthplace Berkley, W. Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name -
13. Birthplace -

MOTHER
14. Maiden Name Becky Womax
15. Birthplace West Virginia

16 (a) Informant Rogelschatz and Coffman
(b) Address Martinsburg, W. Va.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept. 11- (month) (day) (year)
(c) Cemetery or crematory -
Location Martinsburg, W. Va.

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 SEP 11 1947 (Huntington Williams M.D.) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10 1947, at 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 4 1947, to Sept 8 1947, and that I last saw her alive on Sept 6 1947.

Immediate cause of death Pneumonia — Duration ?
Due to
Due to
Other Conditions arteriosclerosis — ?
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —
23. Signature Carl H. Roetling M. D.
Address 1326 W. Lombard St. Date signed 9/10/47

Roetling ×

G55025

LW 112103

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 186a

G55025
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 17-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 550 Oxford St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Emma Morris Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1888

8. AGE: Years	Months	Days	If less than one day: hr.	min.
59	1			

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Jim Morris
13. Birthplace Virginia

MOTHER
14. Maiden Name ? Pickers
15. Birthplace ? Virginia

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 9-13-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 SEP 11 1947 Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6 1947, at 11:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-12 1947, to 9-6- 1947, and that I last saw her alive on 9-6 1947.

Immediate cause of death	Duration
Bronchopneumonia	7 days
Pulmonary infarction	12 hrs.
Due to Debilitation	4 wks.
Due to Intertrochanteric fract of right femur	8 wks
Other Conditions Chronic bronchitis Bronchiectasis	yrs

(Include pregnancy within 3 months of death)

Date of operation 9-15-47

Major findings of operation: —

of autopsy: Dr alone

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 7-9-47 at 7 M
(c) Where did injury occur? Baltimore (City or town) (County) Md (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no
(e) Means of injury Fall

23. Signature W. J. Lucas M. D.
Address Baltimore City Hosp. Date signed 9-10-47

To be approved Howard J. Mullin M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G55026

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 12

R G55026

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Kent
(c) City or town Worton
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stella Louise Jones ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-13-36

8. AGE: Years 11 | Months 3 | Days 28 | If less than one day — hr. — min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Howard Jones

13. Birthplace Del.

MOTHER 14. Maiden Name Viola Clockton

15. Birthplace Md.

16 (a) Informant

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Sept 14 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Colemans
Location WORTON Worton Md Rural

18 (a) Funeral director B. R. Tallows

(b) Address Still Pond Md

19 (a) SEP 11 1947 (b) Huntington Williams M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-10-1947, at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-7-47 to 9-10-1947.
and that I last saw h[illegible] alive on 9-9 1947.

Immediate cause of death Tetanus — Duration 4 days

Due to Stepping on chicken bone 9-1-47

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Tracheotomy 9-9-47
Bone removed 9-7-47

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Acc.
(b) Date of occurrence 9-[illegible]-47 at A M
(c) Where did injury occur? Worton Kent Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? about home While at work?
(Specify type of place)
(e) Means of injury Stepped on chicken bone

23. Signature J. Neill Carnaghi M.D.

Address Johns Hopkins Hosp - Date signed Sept 11, 1947

Howard J. Mercer M.D.

VS 150

X

G55027

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G55027
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3707 Yosemite Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3707 Yosemite Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry L. French Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-03-4035

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife Catherine Collins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1865

8. AGE: Years 81 | Months 11 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore Co. Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name George French
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Switzer
15. Birthplace Penn.

16 (a) Informant Harry French Jr.
(b) Address 3707 Yosemite Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 12, 1947 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 East Biddle Street

19 (a) SEP 11 1947 (b) Rec'd by registrar Washington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10 19 47, at 3 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 7th. 19 47 to Sept. 9 1947
and that I last saw him alive on Sept. 10 19 47

	Duration
Immediate cause of death cardiac insufficiency	ten
Due to chronic myocarditis	mounths
Due to	
Other Conditions senile deteriation	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Willis P. Hall M. D.
Address 4416 Roland Avenue Date signed 9-10-47

Dr Willis P Hall 4416 Roland Ave

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13/a G55028

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 510 Bruce St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-1
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 510 Bruce St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES H. WHITLEY

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: M
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/3/1875

8. AGE: Years 71 | Months 4 | Days 3 | If less than one day hr. min.

9. Birthplace Wash. D.C.
(Town, county, and state)

10. Usual Occupation Unemployed
11. Industry or business Carpenter

FATHER
12. Name Alex. Whitely
13. Birthplace Wash. D.C.

MOTHER
14. Maiden Name Eliza
15. Birthplace Wash. D.C.

16 (a) Informant Alice Dean(
(b) Address 510 Bruce St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A.A.County, Md.

18 (a) Funeral director Charles G. COOPER
(b) Address 510-12 N.Carrollton Ave

19 (a) 11 [illegible] Huntington Williams Collector
(b) Date rec'd by registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/7/47 19 , at 5.00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 4 1947. to Sept 7 1947. and that I last saw h/14 alive on Sept 7 1947.

Immediate cause of death	Duration
Valvular Heart Disease	
Due to Ch. nephritis	
Due to Ch. Prostatitis	1 yr.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Douglas Sheppard
Address 904 Dulany Ave Date signed 9/10/47

G55029

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1176

Registered No. G55029

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline St.

(c) Hospital or institution: St. Joseph's Hosp 10 - 1

(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 1429 E. BIDDLE ST. (If rural give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3 (a) **FULL NAME** McKENNA, Theresa K.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/10/80

8. AGE: Years	Months	Days	If less than one day
67	8	0	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation HOUSEWORK

11. Industry or business

FATHER 12. Name Joseph Moorman

13. Birthplace Germany.

MOTHER 14. Maiden Name Barbara Renner

15. Birthplace Md

16 (a) Informant Mr. J. Moorman

(b) Address 411 N. Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 13th 1947 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Frederick Road

18 (a) Funeral director Lee G. Leach

(b) Address 1701-03 N. Pattison Park ave

19 (a) Received Sep 11 1947 (b) Huntington-Williams Mort (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/10 1947, 11:45A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/31 1947 to 9/10 1947 and that I last saw h CN alive on 9/10 1947

Immediate cause of death UREMIA — Duration

Due to PNEUMONIA

Due to THROMBOPHLEBITIS

Other Conditions DUODENAL ULCER

(Include pregnancy within 3 months of death)

Date of operation 8/27/47

Major findings of operation: DUODENAL ULCER

of autopsy PNEUMONIA, DUODENAL ULCER

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Henry P. Porter M. D.

Address St. Jo. Hosp. Date signed 9/10/47

X

G55030 BC# F59044

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G55030

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore Gen. Hosp. 15-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 Warwick Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James E. Fox

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15-1942

8. AGE: Years 4 | Months 11 | Days 23 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name James E Fox
13. Birthplace Md

MOTHER
14. Maiden Name Anna M Wunderl
15. Birthplace Md

16 (a) Informant Mother
(b) Address 1602 Warwick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-12-47 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Beech Md

18 (a) Funeral director Guy A Farley
(b) Address Fulton & Fay Sts.

19 (a) SEP 11, 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9 1947 at 3:35 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-9-47 at 3:15 P.M. 15/3
(b) Where did injury occur? Eastern Ave & Bentalou St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Struck By Truck

23. Signature Earl L Ryan M.D.
Medical Examiner

Date signed 9-10-47

G55031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G55031

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3020 Walbrook Ave.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3020 Walbrook Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Virginia Broadbent

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ---

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Xxx Joseph F. Broadbent

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26, 1880

8. AGE: Years 67 | Months 4 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name William Skidmore
13. Birthplace Va.

MOTHER
14. Maiden Name Eliza Storm
15. Birthplace Va.

16 (a) Informant Mr. Ashby J. Lewis
(b) Address 3020 Walbrook Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-13-47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director D. Howard Strong
(b) Address 3207 W. North Ave

1947 SEP 11 (Date rec'd by registrar) (b) Funeral for Nottingham, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10 1947, at 6.45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1940 to Sept 10 1947; that I last saw her alive on Sept 9 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	3 days
Due to Arterio sclerosis	8 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Homer H. Todd M. D.
Address 2108 St Paul St Date signed 9/11/47

X

G55032

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 877

G55032 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redcarrod & Green Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4wks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminster.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret R. Nusbaum.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married.

6 (b) Name of husband ~~or wife~~ Harman Nusbaum.
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) May 7, 1910

8. AGE: Years	Months	Days	If less than one day
37	4	4	hr. min.

9. Birthplace Carroll Co. Maryland
(Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name Charles V. Temple
13. Birthplace Maryland.

MOTHER
14. Maiden Name Emma Little
15. Birthplace Maryland.

16 (a) Informant Mr. Harman Nusbaum
(b) Address RD 4 Westminster. Md.

17 (a) Burial (b) Date thereof 9-14-47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~Cemetery~~ Westminster.
Location Westminster. Maryland.

18 (a) Funeral director D. D. Hartzler & Sons.
(b) Address New Windsor, Md.

19 (a) [illegible] (b) Huntington Billingslea M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 11 1947, at 12 ~~M~~ Noon

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1947 to Sept 11 1947 and that I last saw h~~e~~r alive on Sept 11 1947

Immediate cause of death	Duration
respiratory failure	
Due to Multiple Sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. C. Duvall Jr. M.D.
M. D.
Address Date signed

X

G55033 Dr Lewis

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 139a

G55033 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1524- Presstman Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY Francis LEWIS

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Alvin Lewis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1923

8. AGE: Years	Months	Days	If less than one day
24			hr. min.

9. Birthplace Accomac Co. Va.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Alvin Lewis
13. Birthplace Accomac Co. Va

MOTHER
14. Maiden Name Maggie Collins
15. Birthplace Accomac Co Va

16 (a) Informant Hospital records
(b) Address 1524 Presstman St

17 (a) Burial (b) Date thereof 9/14/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Evergreen M E
Location Savagentle, Va.

18 (a) Funeral director J. Edgar Thomas
(b) Address Accomac, Va.

19 (a) SEP 15 1947 (b)
(Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11, 1947, at 1.55 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Cholecystitis
Chronic Salpingitis
Due to

Other Conditions (Operation)
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Edgar Thomas G. Merrill M.D.
Medical Examiner.
Date signed 9-11-47

G55034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G55034

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fenway Court & Hartsdale Rd
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Prince Georges
(c) City or town Laurel
(If outside city or town limits, write RURAL and give town)
(d) Street No. 304 Second St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EVELYN WHIPPLE

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27, 1940

8. AGE: Years	Months	Days	If less than one day
7	2	13	hr. min.

9. Birthplace WASHINGTON, D. C.
(Town, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name Charles D. Whipple
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Bessie Chaney
(b) Address 304 2nd. St. Laurel, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 14, 1947 (month) (day) (year)
(c) Cemetery or crematory Nat. Cap. Mem. Park
Location Meirkirk Md

18 (a) Funeral director Hazlett Sheldon
(b) Address Laurel, Md

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10 1947, at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 6 1947 to Sept 10 1947 and that I last saw h er alive on Sept 10 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Meningitis	2 days
Due to T.B. (suspected)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Done 11 Sept. Johns Hopkins Hospital

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward D. Cooper M. D.
Address Sydenham Hospital Date signed 11 Sept 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly, and legibly.

G55035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48A

G55035 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 327 days
(e) Length of stay in Baltimore (yrs., mos., or days) 327 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Pittsburgh PS
(If outside city or town limits, write RURAL and give town)
(d) Street No. 333 E. General Robinson St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Elizabeth Kelly

3 (b) If veteran, name war

3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1908

8. AGE: Years	Months	Days	If less than one day
39	2	0	hr. min.

9. Birthplace Dawson, W.Va.
(Town, county, and state)
10. Usual Occupation Chambermaid
11. Industry or business Merchant Seaman

FATHER
12. Name Christopher Kelly
13. Birthplace Dawson, W.Va.

MOTHER
14. Maiden Name Blanche Pennington
15. Birthplace Red Creek, W.Va.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (b) Date thereof Sept 13-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Pittsburgh
Location Pennsylvania

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave

19 (a) (b)
(Signature of registrar) Livingston Williams, Registrar

SEP 12 1947

V S 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Sept. 10 1947, at 12:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 18 1946, to Sept. 10 1947, and that I last saw her alive on Sept. 10 1947.

Immediate cause of death (1) Carcinoma of cervix
(2) Regional metastasis to vagina, pelvis and rectum
Due to
Due to
Other Conditions Bilteral ureteral obstruction
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

Duration
Approx. 2 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon
Address Clinical Director Date signed 9/11/47 M. D.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G55036 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3306 Carlisle Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3306 Carlisle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Freeman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Vina nee Freeman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1884

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Merchant

11. Industry or business

FATHER
12. Name Aaron -
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah -
15. Birthplace Russia

16 (a) Informant Aaron Freeman
(b) Address 3306 Carlisle Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 12-47 (month) (day) (year)
(c) Cemetery or crematory United Hebrew
Location Wash. Blvd.

18 (a) Funeral director Jack Levin Inc.
(b) Address 1102 Eutaw Place

19 (a) (b) Date filed by registrar Registrar

SEP 12 1947

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11 1947, at 8 30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 19, 1947 to Sept 11, 1947 and that I last saw h[illegible] alive on Sept. 11, 1947

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension	
Cardio - Vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sigmund Goldberg M. D.
Address 62 W. Lexington St. Date signed 9/11/47

X

G55037 BALTIMORE CITY HEALTH DEPARTMENT G55037
Registered No.

CERTIFICATE OF DEATH 107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 107 N. Montford Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 107 N. Montford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Franklin R. Haddaway

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-05-8946

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Katherine Haddaway
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12 - 1886

8. AGE: Years	Months	Days	If less than one day
61	2	28 yrs	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business Lock Insulator Co.

FATHER
12. Name Charles R. Haddaway
13. Birthplace Md.

MOTHER
14. Maiden Name Not Known
15. Birthplace Md.

16 (a) Informant Katherine Haddaway
(b) Address 107 N. Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 13-47 (month) (day) (year)
(c) Cemetery or crematory Schwartz's Lem.
Location Edonnell

18 (a) Funeral director John J. Miller
(b) Address 2334 Jefferson St.

19 (a) Date received by registrar SEP 12 1947 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 1947, at 11:45 a.m. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1947 to Sept 9 1947, and that I last saw him alive on Sept 9 1947.

Immediate cause of death: Myocardial failure Pul Edema — Duration 24 hrs. 2 mos.
Due to: Myocardial Degeneration
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas S Lofgren M. D.
Address 4321 Patterson Pk Ave Date signed 9/11/47

G55038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 518

G55038
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A A
(c) City or town Baltimore, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 4501 Ritchie Highway (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Maher

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Married

6 (b) Name of husband or wife Mrs Wm Maher
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 27 March 1874

8. AGE: Years	Months	Days	If less than one day
73	5	13	hr. min.

9. Birthplace Pennsylvania Pa.
(Town, county, and state)
10. Usual Occupation IRON WORKER
11. Industry or business

FATHER
12. Name JOHN MAHER.
13. Birthplace - UNKNOWN

MOTHER
14. Maiden Name - "
15. Birthplace - "

16 (a) Informant Franklin Sq. Hosp.
(b) Address FAYETTE & CALHOUN

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9/13/47 (month) (day) (year)
(c) Cemetery or crematory GLEN HAVEN
Location RITCHIE HIGHWAY

18 (a) Funeral director JOHN F. DENNY, INC.
(b) Address 715 LIGHT ST.

19 SEP 12 1947 Filed by registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 10, 1947, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 8, 1947, to Sept 10 1947, and that I last saw him alive on Sept 10 1947.

Immediate cause of death Heart failure, acute — Duration

Due to Pulmonary Pneumonia Rt Middle Lobe

Due to

Other Conditions CA prostate

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Michael K Lyman M.D.
Address Franklin sq. Hosp 108 N. Fayette Date signed Sept 10, 1947

G55039

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52A

G55039 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 241 Ly St.
(c) Hospital or institution: So Balto Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto - #25
(If outside city or town limits, write RURAL and give town)
(d) Street No. 352 - South St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Henrietta Bolden

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-01-5623

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	W

6 (b) Name of husband or wife Leo Harvey
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) 12-10-86

8. AGE: Years	Months	Days	If less than one day
60 61	9	0	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Housemaid
11. Industry or business

FATHER
12. Name William Pierce
13. Birthplace Belle

MOTHER
14. Maiden Name Emeline Dawson
15. Birthplace Belle

16 (a) Informant Hosp Records
(b) Address So Balto Gen.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sat 2 PM (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Frederick Ave

18 (a) Funeral director John F. Denny, Inc.
(b) Address 715 Light St - 30

19 (a) 1947 (b) Received by registrar Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-10 1947 at 6 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-3 1947, to 9-10 1947, and that I last saw h[illegible] alive on 9-10 1947

Immediate cause of death Cardiac arrest
RENAL FAILURE
Due to Thrombosis - renal vein -
Due to pyelonephritis -
Other Conditions Hypertension -
(Include pregnancy within 3 months of death)

Date of operation 9-8-47
Major findings of operations - Hypertension - Gall
of autopsy - on file

Duration

PHYSICIAN
Underline the [illegible] to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address [illegible] Date signed 9-11-47

VS 150

111A

G55040

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G55040 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2122 Mt. Holly St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2122 Mt. Holly St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM ATHERHOLT

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widower

6 (b) Name of husband or wife: Virginia F. Atherholt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 2, 1854

8. AGE: Years	Months	Days	If less than one day
93	6	9	hr. min.

9. Birthplace: Phila., Pa.
(Town, county, and state)
10. Usual Occupation: Brick Burner - retired
11. Industry or business

FATHER
12. Name: Jacob Atherholt
13. Birthplace: Phila., Pa.

MOTHER
14. Maiden Name: Barbara Lentz
15. Birthplace: Phila., Pa.

16 (a) Informant: Mrs. Virginia Vernon
(b) Address: 2122 Mt. Holly St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/47 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) SEP 12 1947 (Date received by registrar) (b) [signature]

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11, 1947 at 3:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1947 to Sept 11 1947 and that I last saw h[im] alive on Sept 11 1947.

Immediate cause of death: Pneumonia-Bronchial
myocarditis — Duration 2 days
Due to: ? —
Due to: —
Other Conditions Arteriosclerosis ?
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter S Nisbett M. D.
Address 2220 Harrison Blvd Date signed Sept. 12/47

X

G55041

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G55041 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Regester St.
(c) Hospital or institution: Mast Balto. Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 149 S. Hilton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH GIUSEPPE CAMPETELLI OR CAMPILLI

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-10-4915

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of wife Josephine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1st 1899

8. AGE: Years	Months	Days	If less than one day
48	8	10	hr. min.

9. Birthplace Castelfrentano-Chieti (Italy)
(Town, county, and state)
10. Usual Occupation Sheet Metal Work
11. Industry or business B.S.Co.

FATHER
12. Name Nick Campetelli
13. Birthplace Italy

MOTHER
14. Maiden Name Agnes ?
15. Birthplace Italy

16 (a) Informant Josephine Campetelli (Wife)
(b) Address 149 S. Hilton St.

17 (a) Burial (b) Date thereof Sept. 13 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery New Cathedral
Location Old Frederick Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) [illegible] (b) Huntington Williams M.D.
Date rec'd by registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-11-47 1947, at 4 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8 / 30 1947 to 9 / 11 1947 and that I last saw h. alive on 9 / 11 1947

Immediate cause of death – Carcinomatosis	Duration
Due to – Carcinoma – Primary Site not determined	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation N.A.
Major findings of operation: Diffuse Carcinomatosis of G.I. tract, of autopsy & Lungs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman Levin
Address W. P. G. H. Date signed 9/11/47 M. D.

G55042 BALTIMORE CITY HEALTH DEPARTMENT X G55042
Registered No.

CERTIFICATE OF DEATH 46B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3204 Batavia Ave
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 14 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Del. (b) County Sussex
(c) City or town Millsboro R.D 1 (If outside city or town limits, write RURAL and give town)
(d) Street No. Rout 1 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles B. Jones
3 (b) If veteran, name war None
3 (c) Social Security Account No. None
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife Elnora B. Hogan Dead.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 24, 1870
8. AGE: Years 77 Months 8 Days 13 If less than one day ____ hr. ____ min.
9. Birthplace Millsboro, Sussex, Del. (Town, county, and state)
10. Usual Occupation Seaman
11. Industry or business Seaman
FATHER 12. Name Burton Jones
13. Birthplace Maryland
MOTHER 14. Maiden Name Unknown
15. Birthplace
16 (a) Informant Ethel E. Dobson
(b) Address 3204 Batavia Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/47 (month) (day) (year)
(c) Cemetery or crematory Mechanics, Millsboro Del
Location Millsboro Del
18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road
19 (a) ____ (b) ____ (Date received by registrar) Registrar

SEP 12 1947
V S 150
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11 1947 at 5.45 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1947 to Sept 11 1947 and that I last saw h.. alive on Sept 11 1947

Immediate cause of death	Duration
Carcinoma of the Stomach	9 mos
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature J. Olesen M.D.
Address 6417 Harford Rd Balto. 14 Date signed 9/12/47 M. D.

G55043

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 99

X G55043 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert Sts.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4d
(e) Length of stay in Baltimore (yrs., mos., or days) 42

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balto.
(c) City or town Govans
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Frederick Zertho

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elsie Zertho

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 26, 1871

8. AGE: Years	Months	Days	If less than one day
76	5	16	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Handy-Man employed by

11. Industry or business Dr. Palmer Williams

FATHER
12. Name Frederick Edward Zertho
13. Birthplace France

MOTHER
14. Maiden Name Anna Stasding
15. Birthplace France

16 (a) Informant Patient
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 13-47 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Randallstown Md.

18 (a) Funeral director Frank H. Neurd
(b) Address Pikesville, Md.

19 (a) [illegible] (b) [illegible]
(Signature of registrar) Huntington Williams, M. D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 11 1947 at 10:17 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 9/8 1947 to 9/11 1947 and that I last saw him alive on 9/11 1947.

Immediate cause of death Heart failure due to chronic auricular fibrillation and heart block due to arteriosclerosis and precipitated by an attack of acute indigestion

Due to

Due to

Other Conditions left leg.

Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No.
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sam Martin Fox M. D.
Address Union Memorial Hosp Date signed 9/11/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55044

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83A G55044 Registered No. 4335-06

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town Bronx, (If outside city or town limits, write RURAL and give town)
(d) Street No. 2830 Morris Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leo Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Molly Miller

6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) 5-15-98

8. AGE: Years	Months	Days	If less than one day
49	3	27	hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation hair dresser

11. Industry or business

FATHER
12. Name Boris Miller
13. Birthplace Russia

MOTHER
14. Maiden Name Lea Shalasman
15. Birthplace Russia

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 9-14-47 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cedar Park Cem Westwood New Jersey

18 (a) Funeral director Jack Lewis Inc

(b) Address 220 Eutaw Place

19 (a) (b) Registrar

SEP 12 1947 rec'd by Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept - 12 - 1947 at 3 25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-5- 1947 to 9-12- 1947 and that I last saw h[illegible] alive on 9-12- 1947.

Immediate cause of death: cerebral hemorrhage — Duration: 3-4 hrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Increased intracranial pressure

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George S Cullreth

Address Johns Hopkins Hosp Date signed Sept 12, 19

G55045

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

G55045 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1302 W Lexington St
(c) Hospital or institution: Home of our Lady (Noursing Home)
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Week
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1032 Aisquith St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country ****

3 (a) FULL NAME Barbara Borgmeier

3 (b) If veteran, name war ****
3 (c) Social Security Account No. ****

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife *****
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 25 1876

8. AGE: Years	Months	Days	If less than one day
71	6	17 16	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Adam Borgmeier
13. Birthplace Germany

MOTHER
14. Maiden Name Mary M Hamper
15. Birthplace Germany

16 (a) Informant Mrs Marie Simpson
(b) Address 4907 Queensbury Ave

17 (a) Burial (b) Date thereof 9/13/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location Belair Rd Baltimore Md

18 (a) Funeral director J Melville Jenkins
(b) Address 2713 Kirk Ave

SEP 12 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 Sept 1947 at 4:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8 Sept 1947, to 10 Sept 1947, and that I last saw h alive on 19

Immediate cause of death Cardiac Respiratory failure — Duration Immediate

Due to Congestive heart failure. — Duration months

Due to — Duration

Other Conditions Arteriosclerosis Chronic Endocarditis.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles Simmons.
Address 910 W. Lombard Date signed 12 Sept 47.

PHYSICIAN

G55046

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 897

G55046 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 418 So. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Kempar

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-0874

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-5-01

8. AGE: Years 46 | Months 9 | Days 7 | If less than one day — hr. — min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 12-47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltor. Co. Md.

18 (a) Funeral director Wm. L. Fialkowski
(b) Address 2007 Eastern ave

19 (a) Huntington Williams, M.D. (Date rec'd by registrar) Registrar

SEP 12 1947 1M 750

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-9-47, at 3:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-9-47, to 9-9-1947. and that I last saw him alive on 9-9-1947.

Immediate cause of death (a) Pulmonary Tuberculosis — Duration 2 hrs

Due to ? Pneumonia

Due to Petrositis + Brain Abscess — 3 wks

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Taylor E. Board M. D.
Address John Hopkins Hosp Date signed 9-10-47
X

G55047

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 113

G55047 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 231 S. High Street. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Millikin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife Anna J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 6, 1920

8. AGE: Years 27 | Months 3 | Days 5 | If less than one day ..... hr. ..... min.

9. Birthplace Hamlet N. C. (Town, county, and state)

10. Usual Occupation Launch Operator

11. Industry or business

FATHER
12. Name Miles L. Milliken
13. Birthplace N. C.

MOTHER
14. Maiden Name Carrie Rushel
15. Birthplace N. C.

16 (a) Informant Mrs. Anna J. Milliken
(b) Address 231 S. High St.

17 (a) Transit (Burial, cremation, or removal) (b) Date thereof Sept. 11 1947 (month) (day) (year)
(c) Cemetery or crematory Mary Love Cem.
Location Hamlet N. C.

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St

19 (a) (Date rec'd by registrar) (b) Washington Williams M.D. Registrar

SEP 12 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11, 1947 at 2.45 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 24-1

(a) Date of injury 9-9-47 at 8.30 p M.
(b) Where did injury occur? Harbor-Fort Mc Henry
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Found drowned-Boat explosion

23. Signature George E. Merrill M.D. Medical Examiner.
Date signed 9-11-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55048

BALTIMORE CITY HEALTH DEPARTMENT ✓ G55048
CERTIFICATE OF DEATH 83A
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2001 Gough Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2001 Gough Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ZACHARKO

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Filemon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 24, 1878

8. AGE: Years	Months	Days	If less than one day
68	9	17	hr. min.

9. Birthplace Wisniowczyk, Austria-Hungary
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Kajtan Wegrzenowicz
13. Birthplace Wisniowczyk, Austria-Hungary

MOTHER
14. Maiden Name Unknown
15. Birthplace Austria-Hungary

16 (a) Informant Mr. James Zacharko
(b) Address 3217 Belair Road

17 (a) Burial (b) Date thereof 9/13/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M.F. Sadowski & Sons
(b) Address [illegible]

19 (a) SEP 12 1947 (b) [illegible] Registrar
(Date rec'd by reg.)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11, 1947, at 7A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 9 1947 to Sept 11 1947 and that I last saw h-r alive on Sept 10 1947.

Immediate cause of death	Duration
Cerebral hemorrhage (Left hemiplegia)	2 days
Due to arterio - sclerosis	years
Due to	
Other Conditions diabetes + vomiting	3 days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Sigmund R. Nowak M. D.
Address 408 S. Patterson Park Ave. Date signed Sept. 12, 1947

VS 150

G55049

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186B

G55049 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 534 W. Lanvale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: CLARK REESE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Willie Mae

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb, 4, 1901

8. AGE: Years 46 | Months 7 | Days 7 | If less than one day hr. min.

9. Birthplace: Eastman Georgia (Town, county, and state)

10. Usual Occupation: Longshoreman

11. Industry or business

FATHER
12. Name: Walter Reese
13. Birthplace: Georgia

MOTHER
14. Maiden Name: Betty ?
15. Birthplace: Georgia

16 (a) Informant: Mrs. Willie Mae Reese
(b) Address: 534 W. Lanvale Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-14-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location U.G. Co. Maryland

18 (a) Funeral director: William A. Johnson
(b) Address: Huntington Williams, MD

SEP 12 1947 (a) (Date received by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 11 1947 at 1:20 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑ or suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH: Perforation of intestine

Peritonitis

~~Due to~~ History of crushing injury To abdomen

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-9-47 at 9 4-1 A.M.
(b) Where did injury occur? Pier #4 - Pratt St
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Struck by ore tub

23. Signature: George L. Merrill M.D. (Medical Examiner.)
Date signed 9/11/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G55050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 930

G55050 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun Sts
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1023 Sarah Ann St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Brown, Turner

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Married

6 (b) Name of husband or wife Bethany Turner
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years	Months	Days	If less than one day
46			hr. min.

9. Birthplace N. C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Mary Brown
15. Birthplace Bethel, N. C.

16 (a) Informant Carrie E. Brown.
(b) Address 1023 Sarah Ann St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-12-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Kate R Williams
(b) Address 322 N. Schroeder St

19 (a) SEP 12 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-9-1947, at 9:22 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-9-1947 to 9-9-1947, and that I last saw h[im] alive on 9-9-1947.

Immediate cause of death Cerebrovascular accident — Duration 4 hrs.
Due to hypertensive heart disease — Duration abt 3 mo.
Due to —
Other Conditions Hepatoma
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations
of autopsy Hepatoma

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert L Richmond
Address 7 Elmley Rd Date signed 9/9/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 D

G55051
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 DA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 937 W Saratoga (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LAWRENCE Brice

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Mary Brice

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1919

8. AGE: Years 28 | Months | Days | If less than one day hr. min.

9. Birthplace Blackstock, S.C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Hattie Moore
15. Birthplace Blackstock, S.C.

16 (a) Informant Mrs. Mary Brice
(b) Address 937 W. Saratoga St.

17 (a) Burial (b) Date thereof 9 (month) (day) 1947 (year)
(Burial, cremation, or removal)

(c) Cemetery or crematory
Location Chester, S.C.

18 (a) Funeral director Mrs Katie B. Williams
(b) Address 322 N Stephen St Huntington Park, Md

SEP 12 1947
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/10/47 19 , at 5:[illegible] M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Adenocarcinoma, Rectum

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 9/10/47

VS 151

G55052 BALTIMORE CITY HEALTH DEPARTMENT ✓ G55052
Registered No.

CERTIFICATE OF DEATH 949

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 446 E. Cross St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 446 E. Cross St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James E. Catterton

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Emma
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 15, 1872

8. AGE: Years	Months	Days	If less than one day
75	5	26	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name unk
13. Birthplace unk

MOTHER
14. Maiden Name unk
15. Birthplace unk

16 (a) Informant Mrs Chas Catterton
(b) Address 446 E. Cross St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 15 47 (month) (day) (year)
(c) Cemetery or crematory Asbury Meml. Park
Location Catonsville Md.

18 (a) Funeral director John F Henry Inc
(b) Address 765 Light St.

19 (a) [redacted] (Local registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 11th 1947 at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/8/ 1947 to 19 ,
and that I last saw him alive on 19 .

Immediate cause of death	Duration
Coronary Thrombosis	2 days
Due to	
Due to	
Other Conditions Senility Arteriosclerosis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Isaac Miller M.D. M. D.
Address 1 W. Pleasant Date signed 9/12/47

G55053

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 124B

G55053 Registered No. 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Charles St + Gittings Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. Veader Leonard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Lucretia
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr) 6-3-88

8. AGE: Years	Months	Days	If less than one day
59	3	8	hr. min.

9. Birthplace N-D. (Town, county, and state)
10. Usual Occupation Physician
11. Industry or business

FATHER 12. Name Harry S. Leonard
13. Birthplace Wash. D.C.

MOTHER 14. Maiden Name Mary Veader
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 13/47 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location North Green Mt. Ave

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place

19 SEP 13 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11 1947 at 9:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 21 1947 to Sept 15 1947 and that I last saw him alive on Sept 15 1947.

Immediate cause of death	Uremia	
Due to	Renal failure	
Due to	Sclerosis	
Other Conditions	Cirrhosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature M Gusack M. D.
Address J. H. H. Date signed 9-11-47

132

G55054 Ad Lydench

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D ✓

Registered No. G55054 54

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 913 N. Port St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 913 N. Port St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Slovac

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wenceslaus Slovac
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) July 30, 1886

8. AGE: Years 61 | Months 1 | Days 10 | If less than one day: XX hr. XX min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Fuka
13. Birthplace Bohemia

MOTHER
14. Maiden Name Catherine Grosch
15. Birthplace Bohemia

16 (a) Informant Wenceslaus Slovac
(b) Address 913 N. Port St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-13-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Joseph Grosch Son
(b) Address 900 N. Chester St

19 SEP 13 1947 (Date rec'd by registrar) (b) Huntingtown Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10, 1947 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 to Sept 10 1947 and that I last saw him alive on Sept 10 1947

Immediate cause of death	Duration
Coronary Thrombosis	9/10/47
Due to Chr Myocarditis	Sept 1947
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Bozarth M. D.
Address 801 Kennedy Ave Date signed 9/13/47

X

C55055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1317

Registered No. C55055 55

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL, and give town)
(d) Street No. 419 So. Bethel St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William Wilson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 56 | Months — | Days — | If less than one day — hr. — min.

9. Birthplace NC. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 13, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location Brooklyn, Md
18 (a) Funeral director Elroy D. Wilson
(b) Address 1000 Blenheim Ave Huntington Williams Md
19 (date rec'd by registrar) SEP 13 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-10-1947, at 5:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-7-1947 to 9-10-1947 and that I last saw h alive on 9-10 1947.

Immediate cause of death Uremia — Duration 1 month

Due to Vascular nephritis

Due to Malignant hypertension 10 yrs

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: as above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Victor G. McKusick M.D.
Address Johns Hopkins Hosp Date signed 9/11/47

G55056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 A

G55056 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3520 Salem St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Powell

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Negro	

6 (b) Name of husband or wife Jane E. Powell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/15/1902

8. AGE: Years	Months	Days	If less than one day
45	Feb	16	hr. min.

9. Birthplace Washington DC
(Town, county, and state)
10. Usual Occupation Produce Dealer
11. Industry or business

FATHER	12. Name James Powell Sr.
	13. Birthplace Caledonia Va
MOTHER	14. Maiden Name Mary ?
	15. Birthplace Caledonia Va

16 (a) Informant Mary E. Powell
(b) Address 2432 Salem Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 13 1942 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Balto Co.

18 (a) Funeral director Wm. Geo. E. Holland
(b) Address 631 Druid Hill Ave

19 (a) SEP 12 1947 (Date received by Registrar) Huntington Williams, M.D. 1514 Division St

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/10 1942 at 7:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/8 1942 to 9/10 1942 and that I last saw h[illegible] alive on 9/10 1942

Immediate cause of death Subarachnoid Hemorrhage — Duration 2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William Garner
Date signed 9/10 1942 (M.D.)

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B

Registered No. G55057 57

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 months

2. USUAL RESIDENCE OF DECEASED:
(a) State West Va. (b) County
(c) City or town Parkersburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. Chancelor Hotel
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME William Henry Schimmel

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mrs. Wm. H. Schimmel

6 (c) If alive, give age: alive 40 years

7. Birth date of deceased (mo., day, yr.) 11/17/1878

8. AGE: Years 68 | Months 9 | Days 25 | If less than one day ..... hr. ..... min.

9. Birthplace: Ohio
(Town, county, and state)

10. Usual Occupation: Civil Engineer

11. Industry or business: W. Va. Dept. of Highways

FATHER
12. Name: Charles Schimmel
13. Birthplace: Ohio

MOTHER
14. Maiden Name: Caroline Marsh
15. Birthplace: Ohio

16 (a) Informant: wife
(b) Address: Chancellor Hotel, Parkersburg W. Va.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9 13 1947 (month) (day) (year)
(c) Cemetery or crematory
Location: Fairmont W. Va.

18 (a) Funeral director: Wm. J. Tickner & Sons
(b) Address: North & Pennsylvania Avenues

19 (a) SEP 13 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 12 1947, at 11:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 17 1947 to Sept. 12 1947, and that I last saw him alive on Sept. 12 1947.

Immediate cause of death	Duration
generalized abdominal carcinomatosis	3 mo.
Due to Carcinoma of the stomach	1 yr.
Other Conditions Generalized basal cell carcinoma	20 yr.
Diabetes mellitus	

(Include pregnancy within 3 months of death)

Date of operation July 16, 1947

Major findings of operation: Carcinoma of stomach

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman R. Freeman Jr. M.D.

Address Union Memorial Hosp. Date signed Sept 12 47

VS 150

C55058

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

46 D

Registered No. C55058

56

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Dailey (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Casper Cutright

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-16-82

8. AGE: Years	Months	Days	If less than one day
65	2	26	hr. min.

9. Birthplace W. Va (Town, county, and state)

10. Usual Occupation Lumberyard

11. Industry or business

FATHER
12. Name Robert Cutright
13. Birthplace W. Va

MOTHER
14. Maiden Name Laverne Cutright
15. Birthplace West Virginia

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof SEPT 13 1947 (month) (day) (year)
(c) Cemetery or crematory ELKINS
Location ELKINS, W. VA.

18 (a) Funeral director WILLIAM COOK FUNERAL
(b) Address 1217 ST PAUL ST. Huntington West Virginia

19 SEP 13 1947 (Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12 1947, at 10:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 27 1947 to Sept 12 1947, and that I last saw him alive on Sept 12 1947.

Immediate cause of death	Duration
CARCINOMA OF RECTUM & PULMONARY EMBOLISM	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation SEPT 3 1947

Major findings of operation: CA of Rectum

of autopsy: PULMONARY EMBOLUS

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard C. Clay M. D.
Address Johns Hopkins Hosp Date signed 9-12-47

X

G55059 ~~3-26-48~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83B 54

Registered No. G55059

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 92 N Madison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. Lee Ellis

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-6-69 ~~9-6-47~~

8. AGE: Years	Months	Days	If less than one day
79	5	5	hr. min.

9. Birthplace Delaware (Town, county, and state)
10. Usual Occupation Physician
11. Industry or business

FATHER
12. Name Wm. R. Ellis
13. Birthplace Delaware

MOTHER
14. Maiden Name Ellen Herr
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial Maried (Burial, cremation, or removal) (b) Date thereof 9/15/47 (month) (day) (year)
(c) Cemetery or crematory Millsboro Cem.
Location Millsboro Delaware

18 (a) Funeral director Wm Cook Inc
(b) Address 317 St Paul St.

SEP 13 1947 (Date rec'd by registrar) (b) Huntington Williams, Md. Registrar

VS 150

MEDICAL CERTIFICATION 46

20. DATE OF DEATH Sept. 11, 1947 at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 27 1947 to Sept. 11 1947 and that I last saw him alive on Sept 11 1947.

Immediate cause of death	Resp. paralysis	
Due to	Cerebral thrombosis	
Due to	Hypertension	
Other Conditions	L. bronchopneumonia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Gunsolus M. D.
Address J. N. H. Date signed 9-15-47

X

G55060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G55060
Registered No. C0

Every item of information should be carefully supplied. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 780 Washington Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IDA BAKER MURPHY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	S Separated

6 (b) Name of husband or wife Raymond

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27 1899

8. AGE: Years	Months	Days	If less than one day
47	9	13	hr. min.

9. Birthplace Balttimore Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles Baker
13. Birthplace Md.

MOTHER
14. Maiden Name Isabella Eipes
15. Birthplace Md.

16 (a) Informant Raymond T. Murphy Jr.
(b) Address 1122 Evansway Armstead Gardens

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md.

18 (a) Funeral director Wilson Funeral Home
(b) Address 1210 E. Fayette St. Baltimore, Md.

19 (a) SEP 13 1947 (Date rec'd by registrar) (b) Funeral Director for Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10, 1947, at 2.15P M

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH acute Congestive Cardiac Failure

Due to Chronic Myocardial Degeneration

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.

Date signed 9-11-47

G55061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G55061 67

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 751 Melville Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 751 Melville Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Charles Loetell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Annie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29. 1873

8. AGE: Years 74 | Months 3 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name William A Loetell
13. Birthplace Alsace Lorraine

MOTHER 14. Maiden Name Wilhelmina Fosteling
15. Birthplace Germany

16 (a) Informant John J Loetell
(b) Address 765 Melville Ave

17 (a) Burial (b) Date thereof 9/13/47 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Md
Location Baltimore Md

18 (a) Funeral director Wilson Co Inc
(b) Address 1217 N Eutaw St

SEP 13 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 11 1947, at 8:54 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1947, to Sept 11 1947, and that I last saw h[im] alive on 8 Sept 1947

Immediate cause of death Acute Coronary thrombosis — Duration 1 Minute

Due to arteriosclerotic Disease. — ?

Due to

Other Conditions Hemiplegia due to cerebral hemorrage — 1 mo.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Silverfine M.D.
Address 714 E Preston Date signed 11 Sept 47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55062

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓50

G55062 Registered No.

1. PLACE OF DEATH: Hardage 5359
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 515 N. Mosher St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Julia Alverta Carr

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Wm. Gillian T.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 11, 1871

8. AGE: Years 75 | Months 11 | Days - | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Richard Johnson
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Jane Baines
15. Birthplace St. Mary's Co. Md

16 (a) Informant Dr. James D. Carr
(b) Address 515 N. Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 13 1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Mrs. George F. Holland
(b) Address 1631 Druid Hill Ave, Md.

19 (a) SEP 12 1947 (b) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/11 1947 at 1:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/9 1947 to 9/11 1947, and that I last saw h[illegible] alive on 9/11 1947.

Immediate cause of death	Duration
CARCINOMATOSIS	
Due to	10 d.
Due to	
Other Conditions	over

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
(f) Signature Bernard Starr
Address 1200 N. Carolina St. Date signed 9/12/47 M.D.

VS 150

G55063

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

Registered No. G55063

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: South Baltimore Gen. Hosp. 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Aronstead Hotel - Fayette
(If rural give location) Holliday
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Franklin V. Smith

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
50			....hr. ....min.

9. Birthplace.....
(Town, county, and state)
10. Usual Occupation.....
11. Industry or business

FATHER
12. Name.....
13. Birthplace

MOTHER
14. Maiden Name.....
15. Birthplace

16 (a) Informant.....
(b) Address

17 (a) Burial (b) Date thereof 9/13/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Ave
18 (a) Funeral director Wm Cook Sr.
(b) Address 1217 E. Baltimore St
19 (a) SEP 13 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1 1947, at 4 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident Probably, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 23-3
(a) Date of injury Found 9-1-47 at 3:15 P M.
(b) Where did injury occur? Found ft of Dickeman St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Found drowned

23. Signature Carl M. Peter M.D.
Medical Examiner
Date signed 9-2-47

VS 151

correct age is especially important. Physicians: please write

X

G55064 HEALTH DEPARTMENT—CITY OF BALTIMORE G55064

CERTIFICATE OF DEATH

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 330 S. Patterson Park Ave. St. 97 Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... da. How long in U. S. If of foreign birth? 5 yrs. ..... mos. ..... da.

2. FULL NAME Bertha Dodson

If U. S. Veteran specify WAR —

(a) Residence: No. 330 S. Patterson Park Ave. Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) 11-29-1866

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
80	9	13 12	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. NONE

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. —

10. Date deceased last worked at this occupation (month and year) —

11. Total time (years) spent in this occupation —

12. BIRTHPLACE (city or town) (State or country) Baltimore Maryland

FATHER

13. NAME Chas. Rosewick

14. BIRTHPLACE (city or town) (State or country) Unknown

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) (State or country) Unknown

17. INFORMANT Dorothy C. Wood

(Address) 230 N. Patterson Pk. Ave.

18. BURIAL, CREMATION, OR REMOVAL

Place Oak Lawn Date 9-15 1947

19. UNDERTAKER Lilly & Zeiler Inc.

(Address) 403 S. Wolfe St.

20. FILED SEP 13 1947 19 Huntington Williams, M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Sept. 11, 1947

22. I HEREBY CERTIFY, That I attended deceased from Dec. 30, 1946 to Mar. 20, 1947

I last saw her alive on Mar. 20, 1947 Death is said to have occurred on the date stated above, at 12 A m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Senility	

Other contributory causes of importance:

arteriosclerosis	years

Was an operation performed? ..... Date of .....

For what disease or injury? .....

Name of operation .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ..... 19.....

Where did injury occur? .....

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased?

..... If so, specify .....

(Signed) Sigmund R. Nowak M. D.

(Address) 408 S. Patterson Park Ave.

X

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1117a

Registered No. G55063

Over

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town [redacted] (If outside city or town limits, write RURAL and give town)
(d) Street No. 11 S. Collington Ave (S.) (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country.....

3 (a) FULL NAME Frank Price

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Anna

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 4-10-90

8. AGE: Years	Months	Days	If less than one day
57	4	26	..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation RIGGER

11. Industry or business STEEL Co.

FATHER
12. Name John Price
13. Birthplace Md

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-15-47 (month) (day) (year)
(c) Cemetery or crematory ST. STANISLAUS
Location DUNDALK AVE.

18 (a) Funeral director LILLY & ZEILER INC.
(b) Address 405 S. WOLFE ST.

19 SEP 13 1947 (Date rec'd by registrar) Washington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11 1947, at 1 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Sept. 11 1947 to Sept 11 1947 and that I last saw h alive on Sept 11 1947.

Immediate cause of death	Duration
Peritonitis	
Due to Perforated peptic ulcer	9 days
Due to	
Other Conditions Thrombophlebitis	

(Include pregnancy within 3 months of death)

Date of operation 9-4-47

Major findings of operation: Peritonitis & perforated ulcer

Autopsy? Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?.....
(e) Means of injury.....

23. Signature Richard C. Clay M. D.

Address Johns Hopkins Hosp. Date signed 9-12-47

X

G55066

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/13B

Registered No. G55066

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 144 N. MILTON AVE.
(c) Hospital or institution:
– NONE –
(d) Length of stay in hospital or inst. (yrs., mos., or days) – 6
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County – – –
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 144 N. MILTON AVE.
(If rural give location)
(e) Citizen of foreign country? YES (Yes or No)
If yes, name country POLAND

3 (a) FULL NAME STELLA WENSKI

3 (b) If veteran, name war –

3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	MARRIED

6 (b) Name of husband or wife J. THEODORE

6 (c) If alive, give age 100 years

7. Birth date of deceased (mo., day, yr.) 8-6-(1885)

8. AGE: Years	Months	Days	If less than one day
52	1	5	....hr. ....min.

9. Birthplace POLAND (Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business HOME

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant J. THEODORE WENSKI
(b) Address 144 N. MILTON AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-15-47 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER CEM
Location BELAIR ROAD

18 (a) Funeral director LILLY & ZEILER INC
(b) Address 902 S. WOLFE ST.

19 (a) SEP 13 1947 (Date rec'd by registrar) Huntington Williams Registrar

V S. 150

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPTEMBER 11 1947, at 7.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from JUNE 1942 to SEPT 1947, and that I last saw her alive on SEPT 11 1947

Immediate cause of death	Duration
PULMONARY TUBERCULOSIS	1 1/2 Y
(PULMONARY HEMORRHAGE	1 HOUR
Due to	
Due to	
Other Conditions LYMPHOID LEUKEMIA	5 YRS

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James F. Kavanagh MD M. D.
Address 3614 W. Fredrick Date signed SEPT. 15-47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55067 GOLDKIND

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 153

Registered No. G55067

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 417 Shepard st N.W. (If rural give location)
(e) Citizen of foreign country? Washington D.C. (Yes or No) If yes, name country

3 (a) FULL NAME Rosalie Goldkind

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Aaron
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 23, 1926

8. AGE: Years	Months	Days	If less than one day
20	10	20	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business House Wife

FATHER
12. Name Morris Cowitz
13. Birthplace Russia

MOTHER
14. Maiden Name Reba Shifren
15. Birthplace Russia

16 (a) Informant Aaron Goldkind
(b) Address 417 Shepard St N.W. Washington

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 14/47 (month) (day) (year)
(c) Cemetery or crematory Brai Israel Cemetery
Location Southern ave

18 (a) Funeral director Sol Levinson Bros
(b) Address 1124-26 W North ave

19 SEP 13 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 12-25

20. DATE OF DEATH September 12, 1947, at P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-23 1947, to 9-12 1947, and that I last saw h e alive on 9-12 1947.

Immediate cause of death	Duration
Acute Dissemenated Lupus Erythematosus	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. A. Wightman M. D.
Address University Hosp Date signed 9-12-47

VS 150

55068

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1250

Registered No. G55068

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4735 Reisterstown Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjiman Ford

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed or divorced: Married

6 (b) Name of husband or wife: Sarah Ford

6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) 12-25-96

8. AGE: Years 50 | Months 9 | Days 18 | If less than one day ___ hr. ___ min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Harris Ford
13. Birthplace Europe

MOTHER 14. Maiden Name Jennie Davis
15. Birthplace Europe

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 14/47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Woodmen of the R[illegible] Cemetery
Location Washington Blvd

18 (a) Funeral director Sol Levinsons Bros
(b) Address 1124-26 W North ave

19 SEP 13 1947 (Date rec'd by registrar) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-12-47, at 9:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-19-1947, to 9-12-1947, and that I last saw [illegible] alive on 9-12-1947.

Immediate cause of death	Duration
Cholemia	
Due to Toxemia	
Due to acute ulcerative colitis	3 mos
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Markley M. D.
Address Johns Hopkins Hosp. Date signed 9/12/47

G55069 O'Bryan

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

Registered No. G55069

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave.
(c) Hospital or institution:
Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4101 Newton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLARA ELIZABETH O'BRYAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife George J. O'Bryan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1890

8. AGE: Years	Months	Days	If less than one day
56	11	21	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Cramblitt
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mamie Nickman
15. Birthplace Balto., Md.

16 (a) Informant Mr. George J. O'Bryan
(b) Address 4101 Newton Ave.

17 (a) Burial (b) Date thereof 9.15.47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 13 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/12/47 1947, at 10:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/2 1947, to 9/12 1947, and that I last saw her alive on 9/12 1947.

Immediate cause of death	Duration
Pulmonary embolism & infarction	
Due to	
Due to	
Other Conditions: diabetes mellitus, abdominal wall abscess	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy: pulmonary embolus

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Thomas Shapiro M.D.
Address Sinai Hosp Date signed 9-12-47

111a

C55070

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. C55070

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians—please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2206 McCulloh Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2206 McCulloh St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James McGill

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-12-5268

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Married

6 (b) Name of ~~husband~~ or wife Elsie J.T.McGill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 26, 1892

8. AGE: Years	Months	Days	If less than one day
55 54	5	15	hr. min.

9. Birthplace Ridgeway, S.C.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Ship Yard, Fairfield, Md.

FATHER
12. Name George McGill
13. Birthplace South Carolina

MOTHER
14. Maiden Name Unknown
15. Birthplace South Carolina

16 (a) Informant Mrs Elsie McGill
(b) Address 2206 McCulloh Street

17 (a) Burial (b) Date thereof 9-16-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Winnsboro, S.C.

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Ave, Balto.1, Md.

19 (a) Date rec'd by (Registrar) SEP 13 1947 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-11-47 19 at 3:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-8-47 19, to 9-11-47 19, and that I last saw him alive on 9-10-47 19

Immediate cause of death	Duration
Cerebral Hemorrhage	3 days
Due to	
Due to	
Other Conditions Generalized Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M Davies Adams, M.D.
Address 238 N Carey St Date signed 9-11-47

X

G55071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

Registered No. G55071

WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 CAROLINE ST.
(c) Hospital or institution: ST JOSEPH HOSP'L
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE TIME

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO MD (If outside city or town limits, write RURAL and give town)
(d) Street No. 2541 AISQUITH ST (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD R. CUMMINGS (EDWIN)

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 215-03-5575

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: LORETTA
6 (c) If alive, give age [illegible] years

7. Birth date of deceased (mo., day, yr.) 8-12-1885

8. AGE: Years 62 | Months 0 | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace BALTO MD (Town, county, and state)
10. Usual Occupation BOOK BINDER
11. Industry or business

FATHER
12. Name James Cummings
13. Birthplace England

MOTHER
14. Maiden Name Mary Buck
15. Birthplace Balto. Md.

16 (a) Informant Mrs Loretta M. Cummings
(b) Address 2541 Aisquith St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-15-1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd.

18 (a) Funeral director Edmund W. Griffin & Son
(b) Address 924 E. Baltimore St

1947 SEP 13 1947 (b) [illegible] Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-11 1947, at 12:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-10 1947 to 9-11 1947, and that I last saw him alive on 9-11 1947.

Immediate cause of death: CARDIO-RESPIRATORY FAILURE — Duration
Due to: CORONARY OCCLUSION
Due to: ARTERIO SCLEROTIC CARD VASC. DISEASE
Other Conditions: MASS IN ABDOMEN. OBSTRUCTION
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John B. Welch M.D.
Address St Joseph's Hosp. Date signed 9-12-47

655072

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 655072

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2877 Mayfield Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2877 Mayfield Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma J. Kerr

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: John Kerr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1867

8. AGE: Years 80 | Months 7 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business

FATHER
12. Name John J. Stribble
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Adeline Dunkley
15. Birthplace Baltimore Md.

16 (a) Informant Miss Mary E. Kerr
(b) Address 2877 Mayfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 16, 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location 3809 Frederick Rd.

18 (a) Funeral director Elmer W. Conkling & Son
(b) Address 924 E. Eager St.

19 (a) Sept 13 1947 Registrar Williams M.D. Registrar

MEDICAL CERTIFICATION 47

20. DATE OF DEATH Sept 12, 1947 at 5:32 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1945 to Sept 11 1947 and that I last saw h[illegible] alive on Sept 11 1947

Immediate cause of death Cardiac decompensation — Duration
Due to Generalized Coronary arteriosclerosis
Due to
Other Conditions Diabetes Mellitus
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M. D.
Address 5217 Harford Road Date signed 9-12-47

V S 150

95c

G55073

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G55073

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12 S. Woodington Road,
(c) Hospital or institution: Convent Sacred Heart Mission Center,
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 12 S. Woodington Road,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Mary Paul Egan,

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: single,
6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 27, 1867

8. AGE: Years 79 | Months 11 | Days 17/3 | If less than one day ... hr. ... min.

9. Birthplace Ireland,
(Town, county, and state)
10. Usual Occupation Nun,
11. Industry or business Convent,

FATHER
12. Name John Egan,
13. Birthplace Ireland,

MOTHER
14. Maiden Name Mary Bones,
15. Birthplace Ireland

16 (a) Informant Sacred Heart Mission Center Records
(b) Address 12 S. Woodington Road.

17 (a) Burial (b) Date thereof 9/13/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Convent of the Mission Helpers Cem.
Location Towson, Md.

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

19 (a) SEP 13 1947 (b) Huntington Hilltop, Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10, 1947 at 10.30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-4 1947 to 8/10/ 1947, and that I last saw her alive on 8/10/ 1947

Immediate cause of death: Chr. Myocarditis — Duration: 2 mos.
Due to: Arteriosclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address 715 Frederick Road, Catonsville, Md. Date signed

V S 150

G55074

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

Registered No. G55074

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 222 W. Monument St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 222 W. Monument St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MISS JULIA ALICE GERNAND

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
About 73			hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Robert Henry Gernand
13. Birthplace Maryland

MOTHER
14. Maiden Name Elisabeth Soldan
15. Birthplace Maryland

16 (a) Informant Mrs Mary G. Keller
(b) Address 222 W. Monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/47 (month) (day) (year)
(c) Cemetery or crematory St. John's
Location Waverly

18 (a) Funeral director N. H. Ulman and Son
(b) Address 805 N. Calvert St

19 SEP 13 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 1947, at 2.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1946 to Sept 12 1947, and that I last saw her alive on Sept 12 1947.

Immediate cause of death	Duration
Myocard. insuff.	6 mo
Due to Chr. valvular heart disease	3 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Chas J Keller M. D.
Address 222 W. Monument St Date signed 9/12/47

VS 150

G550'75

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193

Registered No. G550'73

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Elkridge
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Claude Walter Sellers

3 (b) If veteran, name war 42.

3 (c) Social Security Account No. WW-26-9917

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-29-1918

8. AGE: Years 29 | Months 4 | Days 12 | If less than one day hr. min.

9. Birthplace N. Carolina. (Town, county, and state)

10. Usual Occupation U. S. Concrete Pipe Co.

11. Industry or business

FATHER 12. Name Walter Sellars

13. Birthplace N. C.

MOTHER 14. Maiden Name Mary [illegible]

15. Birthplace N. C.

16 (a) Informant Maria Sellars

(b) Address 251 Conway Street

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/13/47 (month) (day) (year)

(c) Cemetery or crematory Danville Va.

Location Balto. Md.

18 (a) Funeral director Walter P. Scruggs

(b) Address 39 Williams St.

19 (a) SEP 13 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH September 11 1947, at 12:25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Electrocution

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 9-11-47 at 11:40 A.M.

(b) Where did injury occur? U. S. Concrete Pipe Co. Washington Blvd. & Conway

(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? (Yes)

(d) Means of injury Electrocution (Electricity)

23. Signature George L. Merrill M.D. Medical Examiner.

Date signed 9-11-47

X

T 55076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 550 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6907 Harford Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town 6907 Harford Rd
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore Md
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna R. Vogel

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Gustav A Vogel

6 (c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) June 26 1870

8. AGE: Years 77 | Months 2 | Days 15 | If less than one day ....hr. ....min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER 12. Name Geo W. Gray

13. Birthplace England

MOTHER 14. Maiden Name Mary E. Brooks

15. Birthplace Baltimore

16 (a) Informant Mrs. Laura Carr

(b) Address 6907 Harford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sep 13th (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cem

Location City

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2005 Orleans St

SEP 13 1947 (Date rec'd by registrar) Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 11th 1947, at 8:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1947 to Sept 1947 and that I last saw her alive on Sept 8 1947

Immediate cause of death Myo-cardial failure — Duration 3 weeks

Due to Hypertensive Cardio-vascular disease — 2 YEARS

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John H. Hirschfeld M. D.

Address 6919 Harford Rd Date signed 9/12/47

X

G55077

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G55077 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 911 N. Montford ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 911 N. Montford ave (If rural give location)
(e) Citizen of foreign country? Maryland (Yes or No)
If yes, name country

3 (a) FULL NAME August Hess.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 26 1865

8. AGE: Years	Months	Days	If less than one day
79	-	16	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Standard Oil.
11. Industry or business Retired

FATHER
12. Name Henry Hess.
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Gresner.
15. Birthplace Germany

16 (a) Informant Lillian M. Seitz
(b) Address 6300 York Road

17 (a) Burial (b) Date thereof Sept. 13- (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem City.
Location

18 (a) Funeral director Ulrich Funeral Home
(b) Address 1008 Orleans St

19 (a) Huntington Williams (Date rec'd by registrar) (b) Registrar

SEP 13 1947

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 11 1947, at 3:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 2 1947, to Sept 11 47 and that I last saw h alive on 19

Immediate cause of death	Duration
a Cut Cerebrae Thrombosis	9/11/47
Due to Hyp Myocard Sclerosis	5/1/47
Due to Carcinoma of Stomach	9/1/46
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Wallace G. Brown M. D.
Address 801 N. Rutland Ave Date signed 9/10/47

G55078

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

Registered No. G55078

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: University 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 309 S. Gilmor St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edna Vickers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife James Vickers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5 - 1892

8. AGE: Years 55 | Months 6 | Days 5 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER
12. Name John Insinger
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Catherine Reuhl
15. Birthplace Balto Md

16 (a) Informant Mrs. John Insinger
(b) Address 309 S. Gilmor St

17 (a) Burial (b) Date thereof Sept 15 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cem
Location Balto - Md.

18 (a) Funeral director Mamie E. Syfert
(b) Address 1600 W. North Ave

19 SEP 13 1947 (b)
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-10 1947 at 6:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-6 1947 to 9-10 1947 and that I last saw her alive on 9-10 1947.

Immediate cause of death Carcinomatosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John A. Dingbaum M. D.
Address W - A. Date signed 9-10 47

X

G55079 BC# G 28089

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G55079

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2035 E. Pratt St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Clara E. Southall

3 (b) If veteran, name war No
3 (c) Social Security Account No. None

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) July 4, 1945

8. AGE: Years 2 | Months 2 | Days 9 | If less than one day .....hr. .....min.

9. Birthplace Md. Baltimore
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Phillip Southall
13. Birthplace Md

MOTHER
14. Maiden Name Clara Chaikowski
15. Birthplace New York N.Y.

16 (a) Informant Phillip Southall
(b) Address 2035 E. Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/15/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director M. W. E. Dippel & Sons
(b) Address Lombard & Eutaw Sts.

19 (a) SEP 12 1947 (Date rec'd by registrar) (b) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13, 1947 at 12:15 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy/Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 21-1
(a) Date of injury Sept 12th 1947 7:30 P.M.
(b) Where did injury occur? Pratt St. & Chester
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck by truck & auto.

23. Signature Earl M. Hoffman M.D.
Medical Examiner.
Date signed 9-13-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55080

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G55080
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 2 wks

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town Brooklyn 10
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1556 Albany Ave Brooklyn N.Y.
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edmund A. Kilroy

3 (b) If veteran, name war 46

3 (c) Social Security Account No. 100-09-8818

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary E. Kilroy

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) 11/4/1876

8. AGE: Years 70 | Months 10 | Days 7 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore City, Md.
(Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business Atlantic Refining Co.

FATHER
12. Name Michael J. Kilroy
13. Birthplace Wilmington, Dela.

MOTHER
14. Maiden Name Sarah Hawbert
15. Birthplace Baltimore City, Md.

16 (a) Informant Mary E. Kilroy
(b) Address 1576 Albany Ave Brooklyn N.Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) 9 (day) 15 (year) 47

(c) Cemetery or crematory St. Mary's
Location Homeland Ave.

18 (a) Funeral director M. W. E. Doepkin Sons
(b) Address Homeland & Any Sts.

19 (a) SEP 13 1947 (Date rec'd by Registrar) (b) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-11 1947, at 6:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-11- 1947, to 9-11 1947, and that I last saw him alive on 9-11 1947.

Immediate cause of death Cerebral vascular accident

Due to Arteriosclerotic cardiovascular disease

Due to

Other Conditions Cardiac decompensation
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E May M. D.
Address St Josephs Hosp Date signed 9-11-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C55081

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C55081

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 235 S. Robinson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 235 S. Robinson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Philomena (or) Fannie Grill

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Frank Grill
6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Sept. ? 1876

8. AGE: Years	Months	Days	If less than one day
71	-		hr. min.

9. Birthplace Italy
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Daniel Dipollitto
13. Birthplace Italy

MOTHER
14. Maiden Name Domenico ?
15. Birthplace Italy

16 (a) Informant Frank Grill
(b) Address 235 S. Robinson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director W. W. E. Dippel's Sons
(b) Address Lombard & Eden Sts.

19 (a) SEP 13 1947 (Date rec'd by registrar) (b) [illegible] Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11 1947, at 7:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-6-46 19__ to 9-11-47 19__, and that I last saw her alive on 9-11-47 19__

Immediate cause of death	Duration
Arteriosclerotic Cardiovascular Disease	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Constantine M.D.
Address 23 E. Pleasant St. Date signed 9-12-47
M. D.

X

C55082

BALTIMORE CITY HEALTH DEPARTMENT

655082

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 86

655082 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland HARFORD ROAD & HERRING RUN
(b) Street address
(c) Hospital or institution: SYDENHAM HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 N. Gay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELLA MAE KENNEDY

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1944

8. AGE: Years	Months	Days	If less than one day
3			hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Joseph Kennedy
13. Birthplace South Carolina

MOTHER 14. Maiden Name Biner Kennedy
15. Birthplace South Carolina

16 (a) Informant Biner Kennedy
(b) Address South Carolina

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 9-13-47 (month) (day) (year)

(c) Cemetery or crematory
Location Plainview S.C.

18 (a) Funeral director Samuel W. Sullivan
(b) Address 1011 N. Arlington Ave

19 (a) 1947 (Date rec'd by registrar) (b) Jos. Williams, Registrar

V S 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 Sept. 1947 at 8 25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9 Sept 1947 to 10 Sept 1947 and that I last saw her alive on 9 Sept 1947

Immediate cause of death	Duration
Respiratory failure	
Due to Meningitis	1wk (?)
Due to T.B. (suspected)	
Other Conditions	own

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Ronald A. Cooper M. D.
Address Sydenham Hosp. Date signed 10 Sept 47

Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

G55083

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G55083 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2304 Guilford Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2304 Guilford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LLOYD H REVELS

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace Harford Co., Md.
(Town, county, and state)
10. Usual Occupation Minister
11. Industry or business

FATHER
12. Name James H. Revels
13. Birthplace Va.

MOTHER
14. Maiden Name Eliza Toney
15. Birthplace Md.

16 (a) Informant M's Susie Revels
(b) Address 2304 Guilford Ave.

17 (a) Burial (b) Date thereof 9-14-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Tabernacle, Harford Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (b) Registrar
(Signature of person who rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10, 1947, at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947, to Sept. 10 1947, and that I last saw h— alive on Sept. 6 1947.

Immediate cause of death	Duration
Chronic tubercular laryngitis	
Due to	6 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 2529 Guilford Ave Date signed Sept 10 1947

G55084 ..

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G55084
Registered No.

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3712 Sprungdale Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 3712 Sprungdale Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Franklin Klein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sarah

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years: 42 | Months | Days | If less than one day: hr. min.

9. Birthplace: Baltimore Md (town, county, and state)

10. Usual Occupation: Pharmacist

11. Industry or business:

FATHER
12. Name: F. Benjamin Klein
13. Birthplace: Russia

MOTHER
14. Maiden Name: M. Daisy
15. Birthplace: Russia

16 (a) Informant: Sarah Klein
(b) Address: 3712 Sprungdale ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-14-47 (month) (day) (year)
(c) Cemetery or crematory: Har Sinai
Location: Eastern ave

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 2160 Eutaw Place

19 (a) 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-11-1947, at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1936 to Sept 10 1947 and that I last saw him alive on 9-10 1947.

Immediate cause of death: Coronary Thrombosis — Duration: 30 min

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Harvard L Gepford M.D.
Address: 427 Hopkins Pl Date signed 9/12/47

SEP 1

VS 150

G55085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

G55085 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St
(c) Hospital or institution: Home for the Aged Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Hanigan

3 (b) If veteran, name war

3 (c) Social Security account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Aug. 7 1869

8. AGE: Years 78 | Months 1 | Days 5 | (If less than one day) hr. min.

9. Birthplace Anne - Co. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Hanigan
13. Birthplace

MOTHER 14. Maiden Name Bridget O'Shea
15. Birthplace

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St

17 (a) Burial (b) Date thereof Sept. 16, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Alphonsus
Location Woodstock, Md

18 (a) Funeral director F. C. Higinbothom
(b) Address Ellicott City, Md

19 (a) 1947 (b) Thompson Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 1947, at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1947, to Sept 12 1947, and that I last saw her alive on Sept 11 1947

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Cerebral Hemorrhage	3 days
Due to	
Other Conditions Arterio-Sclerosis	5 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E. North Ave Date signed 9/13/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G55086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G55086 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rutland & Monument
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 550 No Gay St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Fonstein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife Eleanor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 61 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Russia (Town, county and state)

10. Usual Occupation Merchant

11. Industry or business

FATHER
12. Name Louis
13. Birthplace Russia

MOTHER
14. Maiden Name Minsky
15. Birthplace Russia

16 (a) Informant Lillian Fonstein
(b) Address 550 No Gay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-14-47 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Hebrew Rest

18 (a) Funeral director Jack Lewis Inc
(b) Address 200 Eutaw Place

19 (a) 1947 [illegible] for Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-14-47 1947 at 2:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-12 1947 to 9-14 1947 and that I last saw h[illegible] alive on 9-14 1947

	Duration
Immediate cause of death Pulmonary Edema	1 hr
Due to Acut & Post myoc infarction	3 + 1/2 days
Due to Coronary thrombosis	3 yrs
Other Conditions Arterial Tbc (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: Myoc. infarction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R E Schenberg MD M. D.
Address Sinai Date signed 9/14/47

X

Please write the causes of death clearly and legibly. Physicians: please specify cause of death, not mode of dying. Every item of information should be carefully supplied. The correct age is especially important. INVA[illegible]

G55087

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 186a

Registered No. G55087

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 926 Peach St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME CEPHAS HARDMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 4/1/1885

8. AGE: Years 62 | Months 5 | Days 10 | If less than one day ..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Joseph Hardman
13. Birthplace Md

MOTHER
14. Maiden Name Annie Brown
15. Birthplace Md

16 (a) Informant Jane Bradley
(b) Address 613 W Barre St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 14 47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A.A. Co Md

18 (a) Funeral director Isaac L Thompson
(b) Address 108 W. Montgomery St.

(a) SEP 24 1947 (Date rec'd by registrar) (b) Martin Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11, 1947, at 6.45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of skull
Intracranial hemorrhage
Due to Contusion of brain
Fractured left ribs

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 22/1

(a) Date of injury 9-7-47 at 10 a. M.
(b) Where did injury occur? 926 Peach St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fell in bath tub

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 9-11-47

VS 181

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55088

BALTIMORE CITY HEALTH DEPARTMENT ✓ G55088
CERTIFICATE OF DEATH 937
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3703 Garrison Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3703 Garrison Ave Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Kathlyn Nee Silesky

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14, 1889

8. AGE: Years 58 | Months 6 | Days - | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business Retired Merchant

FATHER 12. Name Morris Davis
13. Birthplace Russia

MOTHER 14. Maiden Name Leah Spillman
15. Birthplace Russia

16 (a) Informant Dr Marvin Davis
(b) Address 3703 Garrison Blvd

17 (a) Burial (b) Date thereof Sept, 14, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Washing Blvd
Location Washington Blvd

18 (a) Funeral director Sol Lewinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) SEP 14 1947 (b)
(Date rec'd by registrar) Registrar

V S 190

MEDICAL CERTIFICATION 4.30

20. DATE OF DEATH September 14 1947, at A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1942 to Sept 14 1947 and that I last saw him alive on Sept 14 1947.

	Duration
Immediate cause of death Pulmonary Edema	1 hr.
Due to Coronary Occlusion	1 hr.
Due to Arteriosclerotic C.V.D.	unk. yrs
Other Conditions -	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr Hyman M.D.
Address 888 W. Lombard St Date signed 9-14-47 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55089

BALTIMORE CITY HEALTH DEPARTMENT ✓ G55089

CERTIFICATE OF DEATH 46B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 418 N. Payson St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 418 N. Payson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry C. Hauth

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-9236

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Katherine M. Hauth
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) September 1,1875

8. AGE: Years	Months	Days	If less than one day
72	0	11	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Warehouseman
11. Industry or business Wholesale Grocery

FATHER
12. Name Mr. Hauth
13. Birthplace Germany

MOTHER
14. Maiden Name Fredericka ?
15. Birthplace Germany

16 (a) Informant Mrs. Katherine M. Hauth
(b) Address 418 N. Payson St.

17 (a) Burial (b) Date thereof Sept. 15, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore, Md.

18 (a) Funeral director Wallis L. Moorman
(b) Address 4510 Liberty Heights Ave.
(c) Rec'd by registrar Huntington Williams M.D.
(Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 12 1947, at 11.25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 15 1947 to Sept. 11 1947 and that I last saw him alive on Sept. 11 1947.

Immediate cause of death Adeno carcinoma stomach — Duration ?

Due to

Due to

Other Conditions Senility.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elmer Langsdorf M. D.
Address 400 N. Payson St. Date signed 9/13/47

G55090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G55090 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3913 E. Pratt St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3913 E.Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dominic Mastroianni

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War 1	213-07-7432

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	W	Married

6 (b) Name of husband or wife Assunta
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7 1892

8. AGE: Years	Months	Days	If less than one day
54	10	5	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Steel Worker
11. Industry or business Bet. Steel Co.

FATHER
12. Name Vincenzo Mastroianni
13. Birthplace Italy

MOTHER
14. Maiden Name Maria Luisa Nannuzzi
15. Birthplace Italy

16 (a) Informant Assunta Mastroianni (Wife)
(b) Address 3913 E.Pratt St.

17 (a) Burial (b) Date thereof Sept.15/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N.Morley St.

19 (a) Date received by registrar (b) Huntington Williams, M.D. Registrar

SEP 15 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/12 1947, at 5 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/9 1947, to 9/12 1947, and that I last saw h.im alive on 9/12 1947.

Immediate cause of death	Duration
(a) Coronary Occlusion	
Due to (b) Coronary Thrombosis	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature S. C. Feldman M.D.
Address 4451 C Bltm Date signed 9/12/47

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ G55091 Registered No. 119a

Every item of information should be carefully supplied. The coroner's age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Universities Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Rural Pikesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Scottsdale Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

✓

3 (a) FULL NAME IRVIN NELSON

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 20-47

8. AGE: Years | Months: 1 | Days: 2/24 | If less than one day: hr. min.

9. Birthplace [redacted] Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Marcus Nelson
13. Birthplace Md

MOTHER
14. Maiden Name Betty Travis
15. Birthplace N.J.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Mt Lebanon
Location Liberty Rd Sheffield Md

18 (a) Funeral director Frank H. Newell
(b) Address 1100 Reisterstown Rd. Pikesville
(Funeral Home) Pikesville, Md

19 (Date rec'd by registrar) (Registrar)

SEP 10 1947

VS 150

SEP 15 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13 1947, at 3:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-6 1947, to 9-13 1947, and that I last saw h[redacted] alive on 9-13 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to diarrhea	
Due to	
Other Conditions prematurity	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. A. Goldenheimer M. D.
Address Univ Hosp Date signed 9-13-47

X

C55092

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1210

Registered No. C55092

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2418 St Paul St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Kennedy

3 (b) If veteran, name was

3 (c) Social Security Account No. 215-05-7842

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Jessie E

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22 1889

8. AGE: Years 58 | Months 2 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business Sandridge Iron & Metal Co

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden Name "

15. Birthplace

16 (a) Informant Oscar Leibman

(b) Address 5747 Fairlawn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/47 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville Md

18 (a) Funeral director Wilhelm & Son Inc

(b) Address 1217 E Pratt St

19 (a) SEP 14 1947 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/11/47 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-11 19 47 to 9-11 19 47.
and that I last saw h alive on 9-11 19 47.

Immediate cause of death Cardiac failure

Due to Cardio-Vascular Renal disease

Due to

Other Conditions Uremia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Contracted scarred kidneys

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Weitzman

Address Sinai Hosp Date signed 9-12-47

X

PRINT ALL ENTRIES WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55093 — 2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. G55093

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway + Fairmount Ave
(c) Hospital or institution:
Church Home + Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4116 The Alameda (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Carl Muenbauer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or (divorced)

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 2, 1893

8. AGE: Years 54 | Months 6 | Days 11 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Crane adjuster

11. Industry or business

FATHER — 12. Name Mr. Louis Muenbauer
13. Birthplace Germany

MOTHER — 14. Maiden Name Rose Mumford
15. Birthplace Maryland

16 (a) Informant Mr. Carl Muenbauer
(b) Address 4116 The Alameda

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Wilson Godfrey
(b) Address 1217 E. Cold St

19 SEP 15 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13 1947 at 5:37 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 20 1947 to Sept. 13 1947, and that I last saw h[illegible] alive on Sept. 13 1947.

Immediate cause of death: anemia + toxicity — Duration: 5 mo. (known)

Due to: Acute Monocytic Leukemia

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation Sept. 4, 1947

Major findings of operation: Rectal lipoma, Rectal ulceration + ulceration

of autopsy: Pulmonary adhesions

Method of identification

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frederick Robert Haase M. D.

Address Church Home + Hosp. Date signed 9/14/47

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55094

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 134a

Registered No. G55094

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline St.
(c) Hospital or institution: St. Joseph's Hospital 706
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 427 N. Clinton St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie D Wright

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: 4098

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Thomas E. Wright
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Jan. 17, 1910

8. AGE: Years: 37 | Months: 7 | Days: 27 | If less than one day: ____ hr. ____ min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: William Bosso
13. Birthplace: Lithuania

MOTHER
14. Maiden Name: Mary Janulabage
15. Birthplace: Lithuania

16 (a) Informant: Thomas E. Wright
(b) Address: 427 N. Clinton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/17/47 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral Cem
Location: Edmondson Ave

18 (a) Funeral director: Wm Cook Jr.
(b) Address: 217 St Paul St

19 (a) SEP 14 1947 (b) Registrar for Baltimore, Md
SEP 16 1947 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/14/1947, at 5:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/2 1947 to 9/14 1947 and that I last saw h. EIS alive on 9/14/1947

Immediate cause of death: Cardio Respiratory Failure — Duration

Due to: Uremia — Duration

Due to: Nephrolithiasis & Pyelonephritis of One Remaining Functioning Kidney — Duration

Other Conditions: Kidney Impairing Pyelotomy — Duration

(Include pregnancy within 3 months of death)

Date of operation: 9/3/47

Major findings of operation: Renal Calculi Multiple Abscess of Kidney

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Harry T. Watson Jr. M. D.
Address: St Joseph Hosp. Date signed: 9/14/47

X

FOR WHITE REGISTRY, WRITE ONLY WITH BLACK INK. Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G55095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G55095

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 24 S. Fulton ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 24 S. Fulton Avenue
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Sarah J. Whitby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	divorced

6 (b) Name of husband or wife Leonard Wolfe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28, 1897

8. AGE: Years	Months	Days	If less than one day
50	4	15	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Whitby
13. Birthplace Maryland

MOTHER
14. Maiden Name Eleanor ?
15. Birthplace Maryland

16 (a) Informant Mary Finneran
(b) Address 2015 Ashton Street

17 (a) burial (b) Date thereof 9/16/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) SEP 15 1947 Huntington Williams
(Date rec'd by registrar) Registrar

VS SEP 15 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH September 13, 1947, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/1 1947, to 9/13 1947, and that I last saw her alive on 9/12 1947.

Immediate cause of death Carcinoma of cervix — Duration 10 mo.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Pales M. D.
Address 4 N. Fulton Date signed

55096 Boehm

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

123

Registered No. G55096

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2510 Wash Blvd
(c) Hospital or institution:
Md General Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 WK
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2510 Wash Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth M Boehm

3 (b) If veteran, name war ---
3 (c) Social Security Account No. ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Sebastian
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-5-1884 ?

8. AGE: Years	Months	Days	If less than one day
63	3	23	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Geyer
13. Birthplace Md

MOTHER
14. Maiden Name Unknown
15. Birthplace Md

16 (a) Informant Mrs Ida Redifer
(b) Address 2625 Wash Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-15-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd

18 (a) Funeral director Edward Loudon
(b) Address 2359 Wash Blvd

19 (Date received by Registrar) SEP 15 19[illegible] (Huntington Williams, M.D. Registrar)

vs SEP 15 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 1947, at 2:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-4 1947 to 9-12 1947 and that I last saw h[illegible] alive on 9-11 1947 at 11 AM

Immediate cause of death heart failure — Duration 3 days
Due to uremia + 35 Yrs diabetes mellitus undiagnosed — Duration
Due to — Duration
Other Conditions Colloid goiter + thyroid adenoma — Duration 20 yrs +
(Include pregnancy within 3 months of death)

Date of operation none
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no accident
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Eugene A. Patterson M. D.
Address Maryland Gen Hosp Date signed 9-13-47

55097

BALTIMORE CITY HEALTH DEPARTMENT

Hambleton

CERTIFICATE OF DEATH

X 36

Registered No. C55097

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) Balto Co. 9 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore County
(c) City or town Towson-7
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Caroline Hambleton Caroline Hambleton

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: J. Ethel Hambleton
6 (c) If alive, give age 36 years
7. Birth date of deceased (mo., day, yr.) 15 March 1912
8. AGE: Years 35 | Months 5 | Days 29 | If less than one day hr. min.
9. Birthplace Bronxville, New York (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Warren J. Hovratt
13. Birthplace New York

MOTHER
14. Maiden Name Ethel Watt
15. Birthplace Pennsylvania

16 (a) Informant husband
(b) Address Towson-7-Maryland

17 (a) Burial (b) Date thereof Sept 15 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Bel Air Md

18 (a) Funeral director Henry W. Feaheny & Sons Co
(b) Address McCulloh & Orchard Sts

19 (a) SEP 14 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

SEP 15 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 1947, at 9:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1947 to Sept 14 1947, and that I last saw her alive on Sept 14 1947

	Duration
Immediate cause of death: Cardiac regulatory failure - central	24 hrs.
Due to: Bilateral Bronchopneumonitis	12 Days
Due to:	
Other Conditions: Pregnancy - 8th month Fetal death in utero (Include pregnancy within 3 months of death)	

Date of operation: none
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Gustave Chenkin
Address Sydenham Hosp Date signed 9-14-47

File number or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55098

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 108

Registered No. G55098

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St
(c) Hospital or institution: Bon Secour Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1840 W. Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Dowd

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife ✓
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12th 1867

8. AGE: Years	Months	Days	If less than one day
80	4	1	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation House Work
11. Industry or business at home

FATHER
12. Name John H Dowd
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine O'Neill
15. Birthplace Ireland

16 (a) Informant Mr Alexander E. Thompson
(b) Address 1840 W. Baltimore St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/16/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Location 4300 Old Frederick Rd.
18 (a) Funeral director John Carpenter
(b) Address 9007 Hollins St
19 (a) SEP 15 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 Sept 1947 at 1:15 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 9 Sept 1947 to 13 Sept 1947 and that I last saw her alive on 13 Sept 1947.

Immediate cause of death	Duration
Lobar Pneumonia	2 Days
Due to	
Due to	
Other Conditions Bronchial Asthma - Arteriosclerosis - (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Earl L. Royer M. D.
Address 172 Western Pk. Date signed 9/15/47

VS 150

X

G55099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G55099

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3205 Orlando Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3205 Orlando Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emilie A. V. Klein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Edward F. Klein

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 30 - 1947

8. AGE: Years 48 | Months 8 | Days 13 | If less than one day hr. min. 1898

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Wm. Scherer

13. Birthplace Germany

MOTHER 14. Maiden Name Veronica Ruoss

15. Birthplace Germany

16. (a) Informant Edward F. Klein

(b) Address 3205 Orlando Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 15-47 (month) (day) (year)

(c) Cemetery or crematory Balto. Cem.

Location North Ave. & Gay St.

18 (a) Funeral director John F. Miller

(b) Address 2034 Jefferson St.

19 (a) SEP 15 1947 (b) Date rec'd by registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 1947 at 5A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 5 1946 to Sept 12 1947 and that I last saw h[illegible] alive on Sept 12, 1947.

Immediate cause of death Pulmonary Tuberculosis — Duration 2 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: none

of autopsy: No

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence None at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? None While at work?
(Specify type of place)

(e) Means of injury None

23. Signature L. L. Eagle M.D.

Address 5106 Harford Rd. Date signed 9-12-47 (M. D.)

PLEASE WRITE LEGIBLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

55100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 55100

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1905 Division St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1905 Division St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** George L. Blake

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Roxie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1872

8. AGE: Years 74 | Months 9 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Butler

11. Industry or business

FATHER 12. Name Peter Blake
13. Birthplace Baltimore

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Roxie Blake
(b) Address 1905 Division St.

17 (a) Burial (b) Date thereof Sept. 16, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) SEP 15 1947 (b) Huntington Hilligus M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13, 1947, at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/8 1947, to 9/13 1947 and that I last saw h. alive on 9/12 1947.

Immediate cause of death CARCINOMA TOSIS

Due to

Due to

Other Conditions Hypertensive C.V. Disease. Malnutrition
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Porter Grant M.D.
Address 1514 Division St. Date signed 9/15/47

VS 150

X

A RECORD WITH STATISTICS, AND ONE FOR LEGAL PURPOSES. Each item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. G55101

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madeira & Lemden
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3M-13D.
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5112 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry R. Miller

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-18-5739

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Grace C. Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/5/86

8. AGE: Years	Months	Days	If less than one day
61	1	5	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Post office
11. Industry or business

FATHER
12. Name George A. Miller
13. Birthplace Millersville Md

MOTHER
14. Maiden Name Mary Robey
15. Birthplace Maryland

16 (a) Informant Grace C Miller
(b) Address 5112 Edmondson Ave

17 (a) Burial (b) Date thereof Sept 16/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn Md

18 (a) Funeral director Harry R. Amoroso
(b) Address 4204 Ridgewood Ave

19 (a) (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

SEP 16 19[illegible]
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/13 1947 at 6:33 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1 1947 to 9/13 1947.
and that I last saw him alive on 9/13 1947.

Immediate cause of death Carcinoma Duration
Antrum

Due to Postop Pneumonia & Atelectasis

Due to

Other Conditions Carcinoma recto sigmoid junction
(Include pregnancy within 3 months of death)

Date of operation 7/3/47 & 9/10/47

Major findings of operation: CA recto sigmoid & Resection Colostomy

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. A. Mitchell M. D.
Address Bmd. Gen Hosp Date signed 9/13/47

G55102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓ G55102 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette and John St
(c) Hospital or institution: Hospital for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9d.
(e) Length of stay in Baltimore (yrs., mos., or days) approx 2 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town Georgetown, British Guiana, S.A. (If outside city or town limits, write RURAL and give town)
(d) Street No. St. Huberts Main Street (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country British Empire

3 (a) **FULL NAME** Agnes Ruth Humphrey
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband ~~of wife~~ Reginald G. Humphrey
6 (c) If alive, give age 64 years
7. Birth date of deceased (mo., day, yr.) June 21, 1877
8. AGE: Years 70 | Months 2 | Days 23 | If less than one day ..... hr. ..... min.
9. Birthplace Brighton, England (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name George Tidey
13. Birthplace Brighton, England

MOTHER
14. Maiden Name Sarah Ann Mercer
15. Birthplace Brighton, England

16 (a) Informant Daughter, Mrs Kathleen Roberts
(b) Address Same as deceased

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 16/1947 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Hamilton Md

18 (a) Funeral director Harry A Amuso
(b) Address 4204 Edgewood Ave

19 SEP 15 1947 (Date filed by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 13, 1947, at 1:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 5 1947 to Sept 13 1947 and that I last saw her alive on Sept 13 1947.

Immediate cause of death: Cardiac Arrest — Duration:
Due to: Myocardial infarct
Due to: Coronary arteriosclerosis
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: Sept. 13, 1947

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank H. Fogarty M. D.
Address Hosp. Women of Md Date signed 9-13-47

X

G55103

431800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 134B

Registered No. G55103

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 518 S. Durham, St. (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME John Wagner or Wegner

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-20-7955

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	widower

6 (b) Name of husband or wife Mary Wagner (deceased)
6 (c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.) 6-24-1879

8. AGE: Years	Months	Days	If less than one day
68		19	.....hr. .....min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation.....
11. Industry or business.....

FATHER
12. Name George Wagner
13. Birthplace Germany

MOTHER
14. Maiden Name Mietzalend ?
15. Birthplace Germany

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-17-47 (month) (day) (year)
(c) Cemetery or ~~cemetery~~ St. Stanislaus
Location Baltimore, Maryland

18 (a) Funeral director George A Weber
(b) Address 705 S. Bond st

19 (a) SEP 16 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13 - 1947, at 11 5-3 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-8- 1947 to 9-13- 1947, and that I last saw him alive on 9-13- 1947.

Immediate cause of death	Cardiac failure	Duration
Due to	Hypertension	many yrs
Due to	arteriosclerosis	" "
Other Conditions	Bladder stones	

(Include pregnancy within 3 months of death)
Date of operation 9-12-47
Major findings of operation: Bladder stones
of autopsy: arteriosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Perry B Hudson M.D.
Address Johns Hopkins Hosp. Date signed 9-14-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55104

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G55104

Registered No. 13B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mth.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 533 Camel Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALICE GALES

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
Female	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 1904

8. AGE: Years	Months	Days	If less than one day
43	5		hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation domestic
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Adolphus Halstead
(b) Address 918 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-15-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Avenue

19 (a) SEP 15 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11, 1947, at 2.45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Pulmonary tuberculosis
Cirrhosis of liver; Malnutrition; Chronic salpingitis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 9-11-47

C55105

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. C55105

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 420 S. Paca St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Stella Myles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) (Single) married, widowed, or divorced.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12. 1947

8. AGE: Years | Months 3 | Days - | If less than one day hr. min.

9. Birthplace Anundel County Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Marvin Myles
13. Birthplace Anundel Cnty Maryland

MOTHER
14. Maiden Name Susie Banks
15. Birthplace Anundel County Maryland

16 (a) Informant Ella Burley
(b) Address Anundel Cnty Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 15. 1947 (month) (day) (year)
(c) Cemetery or crematory Gamble Cemetery
Location Anundel anne Cnty Md

18 (a) Funeral director Joseph A. Swift
(b) Address 661 West Pane street

19 (a) SEP 15 1947 (b) Date rec'd by Registrar Huntington Williamsport

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/12 1947, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/9 1947, to 9/12 1947, and that I last saw her alive on 9/12 1947.

Immediate cause of death: Anoxia — Duration

Due to: Obstructive airway

Due to: Broncho-pneumonitis

Other Conditions: Bronchiolitis + Pneumonitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John Benson M.D. M. D.

Address University Hosp. Date signed 9/12/47

X

055106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 055106

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 20 E. West Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2?
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 20 E. West Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Enrico Noto

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22-1895

8. AGE: Years	Months	Days	If less than one day
52	4	21	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation self supporting
11. Industry or business

FATHER
12. Name Frank Noto
13. Birthplace Italy

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Grace Lanaca
(b) Address 1106 Marshall Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 16-1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location Old Frederick Rd

18 (a) Funeral director Joseph Tanaca Inc
(b) Address 201 S. Freemont Ave

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

SEP 15 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/13 1947 at 4 00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1947 to Sept 13 1947 and that I last saw h[illegible] alive on Sept 11 1947

Immediate cause of death Coronary Thrombosis — Duration 3 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H B Williams

Address 107 E. West St Date signed 9/14/47 M. D.

X

G55107

AB- 113754

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 937

Registered No. G55107

write the causes of death clearly and legibly. Physicians: please write correct age is especially important. The [illegible] necessary supplies.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 621 S. Regester St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Strzelecki

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Catherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Known

8. AGE: Years 71 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Valentine Strzelecki
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace Poland

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 9-16-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Balto. Md.

18 (a) Funeral director Wm. J. Fialkowski
(b) Address 2007 Eastern Ave

19 (a) [illegible] SEP 15 1947 (b) Huntington Williams, M.D.
(Rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12- 1947, at 10.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-11- 1947, to 9-12- 1947, and that I last saw him alive on 9-12- 1947.

Immediate cause of death	Duration
Cerebro-vascular Accident.	
Due to Hypertensive Cardio-vascular disease.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William A. Yurkanis M.D.
Address Balto. City Hosp. Date signed Sept 13 47

G55108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G55108 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave.
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 7 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5709 Stuart Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JACOB ERNEST FINLEY

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 216-01-3220

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Anna Virginia Finley (nee Gilliece) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 31, 1884

8. AGE: Years	Months	Days	If less than one day
63	5	12	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Shoe Salesman

11. Industry or business I. Miller & Co.

FATHER
12. Name Charles E. Finley
13. Birthplace Md.

MOTHER
14. Maiden Name Laura Torbet
15. Birthplace Pa.

16 (a) Informant Mr. J. E. Finley, Jr.
(b) Address 5709 Stuart Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/16/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 SEP 15 1947 (Date rec'd by registrar) (Huntington for Baltimore, Md.)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/13 1947, at 8 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/24 1947 to 9/13 1947, and that I last saw him alive on 9/12 1947.

Immediate cause of death	Duration
(a) Coronary occlusion	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Sudden myocardial infarction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [signature]
Address Sinai Hosp Date signed 9/13/47 M. D.

VS 150

X

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G55109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195E

Registered No. G55109

Type or print plainly in ink. Fill in all spaces. Be sure the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Blk Light St. DOA
(c) Hospital or institution: South Balto General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1102 Battery Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie Ziegler

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Wm. Ziegler

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Nov. 7, 1887

8. AGE: Years	Months	Days	If less than one day
59	10	5	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Joyce
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Baltimore Md

16 (a) Informant Mrs. Amelia Holland
(b) Address 10 E. Randall St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 16/47 (month), (day), (year)
(c) Cemetery or crematory Cedar Hill Cemetery
Location Patapsco Highways

18 (a) Funeral director Craven Funeral Home
(b) Address 1216 S. Charles St.

19 (a) SEP 15 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/12 1947 at 10:20 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to strangulation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9/12/47 at about 10:00 A 24/3 M.
(b) Where did injury occur? 1102 Battery Ave
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No.
(d) Means of injury Dress caught in washing machine

23. Signature C. P. Valentin M.D. Medical Examiner.

Date signed 9/12/47

X

G55110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G55110

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Hilton Rd
(c) Hospital or institution: Ashburton Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3520 Hilton Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence E. Donaldson

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Edward Donaldson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 9, 1872

8. AGE: Years	Months	Days	If less than one day
75	8	4	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Home Wife
11. Industry or business at Home

FATHER
12. Name Thomas Burgess
13. Birthplace Near Castle Delaware

MOTHER
14. Maiden Name Mary Bien
15. Birthplace York Pa.

16 (a) Informant Mrs. Katherine A. Doffet
(b) Address 1523 Sheffield Rd

17 (a) Burial (b) Date thereof Sept. 16/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd

18 (a) Funeral director Edgar W. Conklin Sr.
(b) Address 924 E. Eager St.

19 (a) SEP 15 1947 (b) Huntington Williamson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13, 1947, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 4 1943 to Sept 13 1947, and that I last saw h[illegible] alive on Sept 13 1947

Immediate cause of death	Duration
Cerebral Hemorrhage	1½ days
Due to Cerebral arteriosclerosis	5 yrs.
Due to Senility	8 yrs.
Other Conditions Fractured hip.	8 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] Chaltant M. D.
Address 6210 York Rd Date signed Sept 15 47

V S 190

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

Registered No. G55111

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Greenmount Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1213 Greenmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Anna McGuire

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John J. McGuire
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1872

8. AGE: Years: 74 | Months: 11 | Days: 23 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Lawrence A. Hannemen
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Helena Geiger
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Helen Lingelbach
(b) Address 3618 Hamilton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 6/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location 4430 Belair Rd

18 (a) Funeral director Edgar W. Conklin's Son
(b) Address 924 E. Eager St.

19 (a) SEP 15 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 11, 1947, at 11:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10 1947 to Sept 11 1947, and that I last saw h. alive on Sept 11 1947.

	Duration
Immediate cause of death: pulmonary edema	1 hr.
Due to: Acute coronary occlusion	1 hr.
Due to: Cardio-Vascular Renal Disease ?	
Other Conditions: Congestive Failure	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Silverfine M.D.
Address 714 E Preston Date signed 17 Sept

V S 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

55112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1312

Registered No. C55112

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and name town)
(d) Street No. 2705 Claflin Ck. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country CLAFLIN

3 (a) FULL NAME Victoria Bennett

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed or divorced: Married

6 (b) Name of husband or wife: Isaac Bennett
6 (c) If alive, [illegible] years

7. Birth date of deceased (mo., day, yr.) 4/15/1899 [illegible]

8. AGE: Years 48 | Months 4 | Days 26 | If less than 1 day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Gwynn Barnes
13. Birthplace Md.

MOTHER
14. Maiden Name Liza
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/15/47 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Baltimore, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave

19 (a) SEP 15 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-10-47 at 505 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-10 1947 to 19; and that I last saw her alive on 9-10-1947.

Immediate cause of death ? Uremia — Duration 5 days
Due to Chronic kidney disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy Protocal of autopsy to be

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No Dept to Med. Examiner
(b) Date of occurrence M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Douglas H Pearce
Address Johns Hopkins Hosp Date signed 9-11 1947

For Dr. C. J. Fahrni
Howard J. Maddox, M.D.

I hereby certify that, with due diligence, I have obtained the correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G55113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G55113 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hosp. 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1818 N. Caroline St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William A. Ruane (William A. Ruane)

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. 217-05-2943

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M.

6 (b) Name of husband or wife: Clementine Ruane

6 (c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.) 5/3/1889

8. AGE: Years 58 | Months 4 | Days 10 | If less than one day ##### min.

9. Birthplace Scranton, Pa (Town, county, and state)

10. Usual Occupation None First Aid Work

11. Industry or business

FATHER
12. Name William W. Ruane
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine O'Neil
15. Birthplace Mass. U.S.A.

16 (a) Informant Clementine Ruane
(b) Address 1818 N. Caroline St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/15/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Frederick Road Balto: Md

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) 1947 (b) Registered by [illegible] Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-13 1947 at 5 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-8 1947 to 9-13 1947; that I last saw h[illegible] alive on 9-12 1947.

Immediate cause of death: Congestive heart failure — Duration:
Due to: Arteriosclerotic heart disease.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature Robert E Mag M. D.
Address St Jo. Hosp Date signed 9-13 47

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117a

Registered No. G55114

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day.
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1615 Monroe St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME John Free

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/3/1903

8. AGE: Years 43 | Months 9 | Days 10 | If less than one day ____ hr. ____ min.

9. Birthplace N.C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business unknown

FATHER
12. Name Louis H. Free
13. Birthplace N.C.

MOTHER
14. Maiden Name Mary Alice Fuller
15. Birthplace N.C.

16 (a) Informant Anne Mae Brown
(b) Address 1615 N. Monroe St

17 (a) Burial (b) Date thereof 9 | 16 | 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Pennsylvania Ave

SEP 15 1947
(Date rec'd by registrar)

(b) Huntington Williams M.D.
Registrar

SEP 15 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/13 1947, at 9:28 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/12 1947 to 9/13 1947 and that I last saw h. alive on 9/13 1947.

Immediate cause of death	Duration
Generalized peritonitis	2 days
Due to Ruptured peptic ulcer	3 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Oswald W. Hoffler

Address Provident Hospital Date signed 9/14/47

X

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G55115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V83a

G55115

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1720 N. Calhoun St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1720 N. Calhoun St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susie Bowman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife Chester Bowman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Samuel Adams
13. Birthplace Md

MOTHER
14. Maiden Name —
15. Birthplace Md

16 (a) Informant Mrs Nellie Coleman
(b) Address 1720 N. Calhoun ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-15-47 (month) (day) (year)
(c) Cemetery or crematory Western Star
Location Md

18 (a) Funeral director Geo. B. Kelso
(b) Address 383 Pulaski St

SEP 16 1947 (Date rec'd by registrar)
(b) Thurlington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13 1947, at 8:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1947, to Sept 13 1947, and that I last saw h. alive on Sept 12 1947.

Immediate cause of death	Duration
Cerebral Hemmorhage	
Due to Malignant Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J W Anderson, M.D.
Address 1536 W. Lanvale Date signed 9-15-47

M. D.

X

G55116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G55116 Registered No.

Write the causes of death clearly and legibly. Physicians: please write correct age in capitals.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Washington
(c) City or town Funkstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Henry Witmer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Pearl E. Weaver
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3, 1918

8. AGE: Years	Months	Days	If less than one day
29	6	9	hr. min.

9. Birthplace Penna (Town, county, and state)
10. Usual Occupation Jockey
11. Industry or business

FATHER
12. Name Henry Witmer
13. Birthplace Pa.

MOTHER
14. Maiden Name ——
15. Birthplace Pa

16 (a) Informant Pearl E. Witmer
(b) Address Funkstown Md

17 (a) Removal (b) Date thereof Sept 16/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Sunbury Penna

18 (a) Funeral director Harry H Witzke
(b) Address 410 E Madison St

19 (a) (b)
(Signature of registrar) Registrar

SEP 15 1947

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 September 1947, at 9:30 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Mediastinal flutter
Traumatic asphyxia
Due to Hemothorax, massive, due to
lacerations of left lung.
Other Conditions Fractures, 5, 6, 7, ribs, left.
Fracture, tibia, fibula, left.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-10-47 at Approx. 2:15 P. M. B.S.T.
(b) Where did injury occur? Timonium Race track
(c) Did injury occur at home, on farm, industrial place, in public place? Race Track While at work? Yes
(d) Means of injury Fell from race horse

23. Signature Wm. R. Kammer, M.D.
Medical Examiner.
Date signed 13 Sept. 1947

G55117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 483a

G55117
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 701 Harlem Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 701 Harlem Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ollie Oram

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Edward Oram

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27, 1898

8. AGE: Years 49 | Months 3 | Days 14 | If less than one day hr. min.

9. Birthplace Charlotte, N. C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Hampton Russell
13. Birthplace N.C.

MOTHER
14. Maiden Name Hannah
15. Birthplace N.C.

16 (a) Informant Edward Oram
(b) Address 701 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-15-1949 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (b)
(Date rec'd by registrar) Huntington Williams, M.D. Registrar

SEP 15 1949

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 1949 at 3:55 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 8 1949 to Sept 10 1949 and that I last saw h alive on 19

Immediate cause of death: Cerebral Hemorrhage — Duration 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address 1547 Harlem Ave Date signed 9/15/49

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

55118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G55118

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2520 Harlem Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2520 Harlem Ave.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME John Z. Davidson

3 (b) If veteran, name war	3 (c) Social Security Account No.
***	***

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Mary D. Davidson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 25, 1875

8. AGE: Years	Months	Days	If less than one day
71	11	18	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name George M. Davidson
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna M. Veasel
15. Birthplace Maryland

16 (a) Informant Miss Rosa Bella Hanaway
(b) Address 2520 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/16/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 (a) SEP 15 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13 1947, at 3 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 30 1947 to Sept 13 1947. and that I last saw him alive on Sept. 12 1947.

Immediate cause of death Myocardial degeneration + insufficiency of Arteriosclerotic type Chronic duration several years.
Due to Generalized arteriosclerosis Cerebral hemorrhage } 3 months
Due to with left sided hemiplegia } 4 days
Other Conditions Infection Right Parotid Gland
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature H. Michel M.D.
Address 2901 Edmondson Date signed Sept 13 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

Qu 57551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. C55119

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1202 Canal Ct. (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME David Benjamin

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-19-47

8. AGE: Years | Months 2 | Days 26 | If less than one day ..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Ernest Benjamin
13. Birthplace S. C.

MOTHER
14. Maiden Name Mary Mickey
15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Sept 15, 47 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brookland, Md
18 (a) Funeral director Elroy O Wilson
(b) Address 1700 Pleasant Ave
19 (a) SEP 15 1947 (b) Thurston Funeral Home, Inc. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12 1947 at 10 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 9 1947 to Sept. 12 1947 and that I last saw h[illegible] alive on Sept 12 1947

Immediate cause of death Bronchopneumonia — Duration
Due to Acute Nutritional Deficiency
Due to .....
Other Conditions .....
(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....
23. Signature J M Edmunds M.D.
Address JHH Date signed 8-13-47

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

VS 150

X

G55120
25-58508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓13B

G55120
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) ?yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 21yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 726 West Fairmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Bazemore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14-1908

8. AGE: Years	Months	Days	If less than one day
39	2	29	hr. min.

9. Birthplace N.C.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Genie Bazemore
13. Birthplace Va.

MOTHER
14. Maiden Name Essie Tidwell
15. Birthplace N.C.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Sept 15 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location Baltimore Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1010 Bentley ave

19 (a) SEP 15 1947 (b) Huntington Hilligoss, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept-13- 19 47, at 9.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-19 19 47 to 9-13- 19 47, and that I last saw h[illegible] alive on 19

Immediate cause of death	Duration
Tuberculosis, pulmonary, far advanced, bilateral	8 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 7-19-43 Thoracoplasty
Major findings of operation: Pulmonary TBC
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Laurence Lee Jr. M. D.
Address Balt. City Hosps Date signed 9-15-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G55121375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓30J

Register No. G55121

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2014 Brunt St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arlene Matthews

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-31-00

8. AGE: Years	Months	Days	If less than one day
47	-	13	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Duffy's
13. Birthplace Dell.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Friends.
(b) Address JOHNS HOPKINS HOSP

17 (a) Burial (b) Date thereof 9/17/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Pleasant Rest
Location Towson Md.

18 (a) Funeral director Metropolitan Funeral Home
(b) Address 923 N. Eutaw St

19 (a) (b) Huntington Pallbearers

SEP 16 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13 1947 at 10 50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 9 1947 to Sept. 13 1947 and that I last saw her alive on Sept. 13 1947

Immediate cause of death	Duration
Staph. Septicemia. Pulmonary edema. Congestive Heart failure	3 days
Due to Myocarditis and mural clot compression	3 weeks +
Due to Luetic aortitis. Aortic aneurysm	years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None.

of autopsy: Aortic Aneurysm. Pulm. Cong.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Gott M. D.

Address Johns Hopkins Hosp Date signed 14 Sept

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √46 B

G55122 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1711 Light St.
(c) Hospital or institution South Balto Gen Hosp 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 14 (If outside city or town limits, write RURAL and give town)
(d) Street No. 2926 Elsinore Cleve (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Henrietta M. Roman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race White

6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Adam Roman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26, 1899

8. AGE: Years 48 | Months 4 | Days 19 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Walter Kamarnaki
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Anna Polek
15. Birthplace Poland

16 (a) Informant son-Severin Roman
(b) Address 3017 Royston Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-17-47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 SEP 15 19[illegible] (Date rec'd by registrar) (b) Thursday for Nativity Mass Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 1947 at 7.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1947 to Sept 12 1947 and that I last saw her alive on Sept 12 1947.

Immediate cause of death Carcinoma of the Stomach — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Hilton M.D.

Address South Balto Gen Hosp Date signed Sept 14

X

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G55123

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md Gneral Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 9
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1411 Northgate Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary A Farrell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Widowed

6 (b) Name of husband or wife Joseph M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 4 1869

8. AGE: Years	Months	Days	If less than one day
77	10	9	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Home
11. Industry or business Home

FATHER
12. Name Patrick Donnelly
13. Birthplace Ireland

MOTHER
14. Maiden Name Ann Mackin
15. Birthplace Ireland

16 (a) Informant Daughter Mrs T Barry
(b) Address 1411 Northgate Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-16-47 (month) (day) (year)
(c) Cemetery or crematory Mt Erin
Location Havre de Grace Md

18 (a) Funeral director E J Ruck
(b) Address 5305 Harford Rd

19 SEP 15 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH 13 Sept, 1947, at 4:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h W alive on Sept 13 19 47

Immediate cause of death Cerebral Thrombosis

Due to Arteriosclerosis

Due to

Other Conditions Hypertension
Acute Rheumatic Disease
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William V. Abeles M. D.
Address Date signed

836

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55124 — BALTIMORE CITY HEALTH DEPARTMENT — G55124

In. 113354

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 532 N. Decker Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David H. Weaver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lillian A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30/1877

8. AGE: Years 70 | Months 3 | Days 14 | If less than one day hr. min.

9. Birthplace Penna.
(Town, county, and state)

10. Usual Occupation Retired Machinist

11. Industry or business

FATHER
12. Name George Harris Weaver
13. Birthplace ?

MOTHER
14. Maiden Name Sarah Houghton
15. Birthplace Penna

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-17-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balt

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

SEP 15 19[illegible] (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 13/ 1947, at 10.25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 26/ 1947 to Sept/13 1947, and that I last saw h im alive on Sept 13th 1947.

	Duration
Immediate cause of death: Uremia	72 hrs
Due to: Hypertensive-Cardio-vascular disease with	
Due to: Glomerulonephritis	10 yrs
Other Conditions: Diabetes	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. S. Lenoir M.D.
Address Baltimore City Hosp Date signed 9/14/47

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important. Information should be carefully supplied. The

VS 190

120

55125 Erhardt

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G55125 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A.
(c) Hospital or institution:
Balto City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 343 S. Drew St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Erhardt

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-18-5042

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. WIDOWED

6 (b) Name of husband or wife ELIZ. ERHARDT

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 29, 1879

8. AGE Years 68 | Months 0 | Days 14 | If less than one day hr. min.

9. Birthplace BALTO. MD.
(Town, county, and state)

10. Usual Occupation LABORER.

11. Industry or business FRANKFORD DIST. Co.

FATHER 12. Name FRANK J. ERHARDT

13. Birthplace GERMANY

MOTHER 14. Maiden Name ANNA ADELMANN

15. Birthplace ?

16 (a) Informant FRANK J. ERHARDT (SON)
(b) Address 343 S. DREW ST.

17 (a) BURIAL (b) Date thereof 9-17-47.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory SACRED HEART CEM
Location GERMAN HILL RD.

18 (a) Funeral director Charles S. Zeiler
(b) Address 901 S. CONKLING ST.

19 SEP 15 1947 (b) Huntington Williams M.D.
(Date received by Registrar) (Registrar)

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MEDICAL CERTIFICATION

20. DATE OF DEATH 9/13 1947, at 8:50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic C.V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Friedrichs M.D.
Medical Examiner.
Date signed 9/14/47

X

G55126

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

92 B

Registered No. G55126

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave & Madison St.
(c) Hospital or institution Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Cedar Beach (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lillian Sewell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife Clifton N

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years 45 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Wm Steele
13. Birthplace Balto

MOTHER
14. Maiden Name Dora Eisenberg
15. Birthplace Balto Md

16 (a) Informant Clifton Sewell
(b) Address Cedar Beach

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 16 47 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Baltimore Md

18 (a) Funeral director J Bruce Grisbe
(b) Address 1405 Eastern Ave Rd

19 (a) SEP 15 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 Sept 1947, at 5:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12 Sept 1947 to 12 Sept 1947 and that I last saw h. alive on 12 Sept 1947.

	Duration
Immediate cause of death Circulatory failure	2 days
Due to Rheumatic cardiovascular disease	8 yrs
Due to	
Other Conditions Embolism both femoral arteries	

(Include pregnancy within 3 months of death)

Date of operation 12 Sept 47

Major findings of operation: Embolism both femoral arteries

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Allan Spurr M.D.
Address Md. Gen. Hosp. Date signed 12 Sept 47

VS 150

G55127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G55127

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Temple Garden Apt's.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Balto.
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JACOB DASHEW

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Flora Dashew
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/15/1879

8. AGE: Years 68 | Months 7 | Days 29 | If less than one day: hr. min.

9. Birthplace RUSSIa (Town, county, and state)

10. Usual Occupation Machinery Merchant

11. Industry or business

FATHER
12. Name Solomon A. Dashew
13. Birthplace Russia

MOTHER
14. Maiden Name UNknown
15. Birthplace Russia

16 (a) Informant Mrs. Flora Dashew
(b) Address Temple Garden Apt's.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 17, 47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Philadelphia Rd. (City)

18 (a) Funeral director [illegible]
(b) Address 1902 Eutaw Place,

19 (a) (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23 must be answered. Physicians: please write the causes of death clearly and legibly. Be sure that your certificate is complete and correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14th 1947 at 5:35 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from July 1947 to Sept. 14th 1947.
and that I last saw him alive on Sept. 14th 1947

Immediate cause of death	Duration
Coronary Occlusion	12 hrs.
Due to Arteriosclerotic Heart Disease	6 yrs.
Due to Coronary Artery Sclerosis	6½ yrs.
Other Conditions Myocardial Insufficiency Chronic Gastric Ulcer	6 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Irvin Pinkard M.D.
Address Emerson Bldg. Balto. Date signed Sept 14, 1947

G55128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G55128
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Ingraham Hall Apts
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13'
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Esplanade Apts
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Alvine Wisebergs Lyon
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife Benjamin B Lyon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 14 1871

8. AGE: Years	Months	Days	If less than one day
76	7	27	hr. min.

9. Birthplace Atlanta Ga.
(Town, county, and state)
10. Usual Occupation Home
11. Industry or business

FATHER
12. Name Morris Wisebergs
13. Birthplace Germany

MOTHER
14. Maiden Name Clara Hirschfield
15. Birthplace Germany

16 (a) Informant Mrs Benjamin Meyer
(b) Address Ingraham Hall Apts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/16/47 (month) (day) (year)
(c) Cemetery or crematory Har Sinai
Location Balto. Md.

18 (a) Funeral director Harris Levin Co.
(b) Address 1902 Eutaw Place

19 (a) Date received by registrar (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13 1947, at 1 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1947, to Sept 13 1947, and that I last saw h.e.r. alive on Sept 13 1947.

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to Arterio - sclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Wisebergs Lyon M. D.
Address 1902 Eutaw Pl Date signed 9/13/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G55129

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2036 Hollins Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2036 Hollins Street
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine A. Neubauer

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: George A.
6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1861

8. AGE: Years 86 | Months — | Days 1 | If less than one day: hr. ___ min. ___

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Peter Phillippi
13. Birthplace Germany

MOTHER
14. Maiden Name Regina Rodser
15. Birthplace Germany

16 (a) Informant Anna L. Kettler
(b) Address 2036 Hollins Street

17 (a) Burial (b) Date thereof 9-17-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director George L. Schwab
(b) Address 2101 W. Frederick Ave

19 (a) SEP 15 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14 1947, at 9:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from January 1942 to Sept. 14 1947, and that I last saw h[illegible] alive on Sept. 12 1947.

	Duration
Immediate cause of death: Myocardial degeneration and insufficiency with congestive failure	3 months
Due to: Arterio sclerotic type of heart disease with hypertension & hypertrophy	4 yrs
Due to: Generalized arterio sclerosis	

Other Conditions: Cerebral arterio sclerosis with edema
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Dr. Michel M. D.
Address 2901 Edmondson Ave Date signed Sept 17 1947

X

Please write the causes of death clearly and legibly. Physicians: please state, briefly, cause, or causes, of death, and the contributory causes which gave rise to the mentioned primary cause, in such terms as will express fully their etiologic relationship. Indefinite and unsatisfactory terms, such as "senility," "old age," "exhaustion," "cardiac failure," "heart failure," "uremia," "convulsions," "hemorrhage," "shock," "pneumonia," "tuberculosis," should be carefully supplied. The correct age is especially important.

G55130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 43a

Registered No. G55130

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2761 Alameda
(c) Hospital or institution: 9-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2761 Alameda (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William L. Wagner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of ~~Husband~~ or wife Matilda Price

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16, 1869

8. AGE: Years 78 | Months 1 | Days 27 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Tailoring Foreman

11. Industry or business

FATHER 12. Name Gottlieb Wagner
13. Birthplace Germany

MOTHER 14. Maiden Name Not Known
15. Birthplace Germany

16 (a) Informant Wm Potts
(b) Address 2761 Alameda

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/16/47 (month) (day) (year)
(c) Cemetery or crematory Balto
Location Balto Md.

18 (a) Funeral director E. J. Fanning & Son
(b) Address 1938 E. Lafayette Ave.

19 (a) (Date received by Registrar) SEP 16 1947 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13 1947; at 9 1/2 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1947 to Sept 13 1947 and that I last saw him alive on Sept 13 1947.

Immediate cause of death	Duration
Cerebral hemorrhage	10 da
Due to	
Secondary to Cerebral Hemorrhage	7 yr
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 2700 Harford Road Date signed Sept 15 1947

G55131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G55131
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2518 W. Baltimore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2518 W. Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary T. McEnaney

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: John C. McEnaney
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov 14th 1869
8. AGE: Years 77 | Months 9 | Days 30 | If less than one day hr. min.
9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation House Work
11. Industry or business at home

FATHER
12. Name Thomas Cronin
13. Birthplace Ireland

MOTHER
14. Maiden Name Unknown
15. Birthplace Ireland

16 (a) Informant Mrs. James J. Ryan
(b) Address 2518 W. Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/17/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location 4300 Old Frederick Rd

18 (a) Funeral director John J. Logan & Son
(b) Address 901-03 Hollins St

19 (a) (Registrar) (b) Thursday for Williamsport, Md

S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13th 1947, at 7:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1947, to Sept 13 1947, and that I last saw h. alive on Sept 13 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Bronchopneumonia	
Due to	
Other Conditions Arteriosclerotic Cardio-Vascular Disease	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Albert Scognamiglio
Address 724 W Lanvale St Date signed Sept 15 M. D. '47

SEP 15 1947

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Page is especially important. Physicians: please write the causes of death clearly and legibly. Any

435088 G55132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 157E

G55132 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. Copy supplied. 1948

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. J. (b) County
(c) City or town Pennsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 47 Oak St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carolyn Lee Press

3 (b) If veteran, name war

3 (c) Social Security Account No.

Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-18-43

8. AGE: Years 4 | Months 1 | Days 28 | If less than one day hr. min.

9. Birthplace N. J. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Earl Press
13. Birthplace Pa

MOTHER 14. Maiden Name Edith E Chambers
15. Birthplace N. J

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof 9/19/47 (month) (day) (year)
(c) Cemetery or crematory Baptist
Location Salem New Jersey

18 (a) Funeral director John O Smith Sons
(b) Address 1800 Easton Pk.

19 (a) (Date received by registrar) (b) Registrar Huntington Williams, M.D.

SEP 15 1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15, 1947, at 10 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1947, to Sept 15 1947, and that I last saw h alive on Sept 15 1947.

Immediate cause of death Heart Failure — Duration

Due to Congenital Heart Disease Tetralogy of Fallot

Due to

Other Conditions ? Cerebral Thrombosis

(Include pregnancy within 3 months of death)

Date of operation 9/15/47

Major findings of operation: Dextrocardia Stenosis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James R. Cantrell M. D.
Address The Johns Hopkins Hosp Date signed 9/15/47

X

G55133 BC# G85550 BALTIMORE CITY HEALTH DEPARTMENT G55133
Gorman CERTIFICATE OF DEATH 107 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hrs 45 min
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 102 E. Susquehanna Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Barman Lee Eaton

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 5, 1947

8. AGE: Years	Months	Days	If less than one day
	1	9	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name T. Paul Eaton
13. Birthplace Maryland

MOTHER
14. Maiden Name Hallie Sterner
15. Birthplace York, Pa.

16 (a) Informant Mother
(b) Address Same

17 (a) Burial (b) Date thereof Sept. 17 1947
(burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Prospect Hill Cem
Location Towson, Md.
18 (a) Funeral director John Burns' Sons
(b) Address Towson, Md.
19 (a) SEP 15 1947 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 1947 at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 14 1947 to Sept 14 1947 and that I last saw him alive on Sept 14 1947

Immediate cause of death: Aspiration Pneumonia — Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. Brady Lee, M. D.
Address Md. Date signed 9-14-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G55134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G55134 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3122 Foster ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days) 65 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3122 Foster ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Kulinski

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Michael Kulinski

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jacob Zdziarski
13. Birthplace Poland

MOTHER
14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Emilia Podgorski
(b) Address 3122 Foster ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-16-47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Balto. County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 SEP 16 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

S 27

20. DATE OF DEATH Sept. 13 1947 at 4 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Aug. 15 1947 to Sept. 13 1947 and that I last saw h-- alive on Sept. 13 1947

Immediate cause of death: Cerebral Thrombosis — Duration: 2 days
Due to: Arteriosclerosis
Due to: Chr. Hypertension — ?
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Zdziarski M. D.
Address 3122 Foster ave Date signed 9/13/47

VS 150

X

G55135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

309

Registered No. G 55135

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1639 Durham Ste
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1639 Durham Ste
(If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Anna H. Lampe

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Jacob B. Lampe
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) July 25-1883

8. AGE: Years 64 | Months 1 | Days 18 | If less than one day ____ hr. ____ min.

9. Birthplace Penna (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business at Home

FATHER
12. Name Daniel Hanley
13. Birthplace Pa

MOTHER
14. Maiden Name Eliz Donnelly
15. Birthplace Pa.

16 (a) Informant Mr. Jacob Lampe
(b) Address 1639 Durham ste

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 16-47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location 61 Donnell Sta Rd

18 (a) Funeral director John G. Donnelly
(b) Address 4611 Eastern Ave.

SEP 16 1947 (Date rec'd by registrar) (b) Huntington for Williamsburg, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 1947, at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1947 to Sept 12 1947, and that I last saw h[illegible] alive on Sept 12 1947

Immediate cause of death Arteriosclerotic cardio vascular Disease — Duration

Due to Hypertension

Due to

Other Conditions Lues

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Conrad L. Rutty M.D.
Address 1706 N. Wash. St Date signed 9/15/47

VS 150

X

Write the causes of death clearly and legibly. Physicians: please write to correct age is especially important.

G55136
JL - 113761

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G55136
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important. Necessary supplies are furnished free.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 26-11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 625 S. Clinton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Delmar Cooper

3 (b) If veteran, name war: Hold Stan II
3 (c) Social Security Account No. 234-22-274

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-1-75 1918

8. AGE: Years	Months	Days	If less than one day
29	6	20/7	hr. min.

9. Birthplace W. Va.
(Town, county, and state)
10. Usual Occupation Tin mill
11. Industry or business Bethl Steel Co.

FATHER
12. Name J. G. Cooper
13. Birthplace W. Va.

MOTHER
14. Maiden Name Grace Cooper
15. Birthplace W. Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Transportation (b) Date thereof Sept. 15-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Summers Co. W. Va.

18 (a) Funeral director John B. Connelly
(b) Address 418 Eastern Ave. Baltimore

19 (a) (Date rec'd by registrar) (b) M. Lee Williams Registrar

SEP 15 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14 19 47 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 12 19 47 to Sept. 14 19 47 and that I last saw h. in alive on Sept. 14 19 47.

Immediate cause of death Cardiac depression due to intracranial pressure — Duration

Due to Intracerebral Lemorrhage and Sub-arachnoid Hem.

Due to Hypertension

Other Conditions Extradural + Sub-dural Hematoma
(Include pregnancy within 3 months of death)

Date of operation 9/14/47

Major findings of operation: Subdural Hematoma intracerebral, subarachnoid of autopsy extra + subdural hem.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 26/9
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 9/12/47 at ? M
(c) Where did injury occur? Eastern Avenue & Caroline Street
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public While at work? No
(Specify type of place)
(e) Means of injury Fell to street striking head

23. Signature K. M. N. Crosby
Address Balto City Hosp. Date signed 9/15/47

To be approved by Medical Examiner
H. J. W. Davis, M.D.
Howard J. Davis M.D.

G55137 BCH B-29970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5413

G55137

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1202 McElderry Ct.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1202 McElderry Ct., Apt A2 (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME William Douglas Perry.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: C.

6 (a) Single, married, widowed, or divorced. ✓

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 9. 1945

8. AGE: Years 2 | Months 1 | Days 4 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Perry.
13. Birthplace ~~Md~~ Va.

MOTHER
14. Maiden Name Copeland.
15. Birthplace Va.

16 (a) Informant James Perry
(b) Address 1202 McElderry Ct

17 (a) Burial, (cremation, or removal) (b) Date thereof 9/14/47 (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director Robert E. Williams
(b) Address 1515 McElderry St.

SEP 16 1947 (c) Signature of local registrar (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13 1947 at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-7- 1947 to 9-13- 1947 and that I last saw h. alive on 9-12-1947

Immediate cause of death Peritonitis
Tumor of brain

Duration 2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None

of autopsy

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John G. T. Camper M. D.
Address 629 N. Carey Date signed 9-16-47

X

5138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1707

Registered No. G55138

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22
(c) Hospital or institution: South Baltimore Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3 W. Hill St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roland L. Ridge

3 (b) If veteran, name war —

3 (c) Social Security Account No. 219-18-7985

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife HELEN RIDGE
6 (c) If alive, give age 20 years

7. Birth date of deceased (mo., day, yr.) JAN. 11, 1925

8. AGE: Years	Months	Days	If less than one day
22	8	2	....hr. ....min.

9. Birthplace BALTIMORE, MARYLAND
(Town, county, and state)

10. Usual Occupation WELDER

11. Industry or business

FATHER
12. Name COLUMBUS W. RIDGE
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name ETHEL COMEGYS
15. Birthplace BALTIMORE, MD

16 (a) Informant MRS COLUMBUS RIDGE
(b) Address 3 W. HILL ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9/16/47 (month) (day) (year)
(c) Cemetery or crematory LOUDAN PARK
Location FREDERICK RD.

18 (a) Funeral director JOHN F. DENNY, INC.
(b) Address 715 LIGHT ST.

SEP 16 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13, 1947, at 3-55 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Its death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH (a) Fracture of Skull & intracranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: a.a. Hon
(a) Date of injury 9/6/47 at 12:20 A. M.
(b) Where did injury occur? Ritchie Highway nr Ellenborough
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Motorcycle ran into Car

23. Signature [signature] M.D.
Medical Examiner.
Date signed 9-13-47

55139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

G55139 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address East 33d St.
(c) Hospital or institution: Union Memorial Hosp. 27-14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 212 Woodlawn Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Eugene Martinet

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mary M. Martinet
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 9, 1892

8. AGE: Years	Months	Days	If less than one day
55	3	6	..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Musician
11. Industry or business

FATHER
12. Name Oscar C. Martinet
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna Walker
15. Birthplace Maryland

16 (a) Informant Mrs. Mary M. Martinet
(b) Address 212 Woodlawn Rd Balto

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-17-47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Pulliam Bros Inc
(b) Address 219 E Saratoga St

SEP 16 1947 (Date filed) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-15 1947, at 7:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-7 1947 to 9-15 1947, and that I last saw him alive on 9-15 1947.

Immediate cause of death	Duration
Cardiac Decomp. failure	1 wk
Due to Laennec's Cirrhosis with ascites	2 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature A. Wade Abbott M. D.
Address Union Memorial Hosp. Date signed 9-17-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. G55140

write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rutland & Monument
(c) Hospital or institution:
Sinai Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 222 Poplar Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ralph Godfrey

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Dorothy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 10 1903

8. AGE: Years	Months	Days	If less than one day
43	11	3	hr. min.

9. Birthplace W Va.
(Town, county, and state)
10. Usual Occupation Merchant
11. Industry or business

FATHER	12. Name John W Godfrey
	13. Birthplace W Va
MOTHER	14. Maiden Name Cora McCord
	15. Birthplace W Va

16 (a) Informant Dorothy Godfrey
(b) Address Essex Md

17 (a) Sinai (b) Date thereof 9/13/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem
Location Baltimore Md

18 (a) Funeral director Pallhorn & Son
(b) Address 1217 Eutaw St

SEP 16 1947 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/13 1947 at 1:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/11/47 to 9/13 1947 and that I last saw h. alive on 9/13 1947.

Immediate cause of death	Duration
Pneumonia	2 days
Due to Lymphosarcoma	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Lymphosarcoma

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature KE Colonberg MD
Address Sinai Date signed 9/14/47 M. D.

55141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55141 / 1063

Registered No. G55141

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 726 West Hamburg Street
(c) Hospital or institution: ////////////////////
(d) Length of stay in hospital or inst. (yrs., mos., or days) ////
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County .....
(c) City or town Baltimore Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 726 West Hamburg St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country .....

3 (a) FULL NAME CHARLES E. BURKE

3 (b) If veteran, name war -

3 (c) Social Security Account No. ////////

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Helen C. Burke
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Jan. 4 th. 1879

8. AGE: Years	Months	Days	If less than one day
68	8	9	//// hr. //// min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation ////////////
11. Industry or business ////////////

FATHER
12. Name Charles E. Burke
13. Birthplace Maryland

MOTHER
14. Maiden Name Jane McPhail
15. Birthplace Maryland

16 (a) Informant Mrs. Helen C. Burk (wife)
(b) Address 726 W. Hamburg Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 16/47 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore Maryland

18 (a) Funeral director F. B. WIPPERT & SON
(b) Address 1300 EUTAW PLACE.....17

19 (c) SEP 16 1947 (Date received by registrar) Municipal for Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 13 1947, at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 16 1947 to Sept 13 1947 and that I last saw him alive on Sept 13 1947

Immediate cause of death	Duration
Auricular Fibrillation	1 hr.
Due to Chronic Bronchitis	6 Mo.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature Harry Kates M. D.
Address 517 Scott Street Date signed .....

Dr. Kates.

55142 JL - 112632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No. G55142

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1621 Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Semi Mufraj

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1, 1889

8. AGE: Years	Months	Days	If less than one day
57	11	14	hr. min.

9. Birthplace Syria
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Abdulla (D)
13. Birthplace Syria

MOTHER
14. Maiden Name Roda
15. Birthplace Syria

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 9/16/1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location G. G. Co. Md.

18 (a) Funeral director Flynn & Fulgenzi
(b) Address 1426 Light St.

19 (c) SEP 16 1947 (b) Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15 19 47 at 4.45A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 31 19 47 to Sept. 9 19 47, and that I last saw h im alive on Sept. 15 19 47.

Immediate cause of death	Duration
Massive hemoptysis	5 min
Due to Erosion of bronchial artery, right upper lobe	
Due to Tuberculosis of lungs for 4 years	20 yr
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: see above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ralph T. Brown Jr M. D.
Address Balt. City Hosp. Date signed 9-15-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

55143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G55143 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert 133 & 5C
(c) Hospital or institution: Union Memorial Hospital 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1305 John St (If rural give location)
(e) Citizen of foreign country? [illegible] (Yes or No) If yes, name country

3 (a) FULL NAME Joshua W. Lockwood

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 19, 1869

8. AGE: Years	Months	Days	If less than one day
78	6	26	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name Joshua W. Lockwood
13. Birthplace Virginia

MOTHER 14. Maiden Name Anna Fitzhugh
15. Birthplace Virginia

16 (a) Informant Ethel B. Lockwood
(b) Address 1305 John St, Baltimore, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/17/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Hollywood
Location Richmond, Va

18 (a) Funeral director John O'Neill & Sons
(b) Address 900 Eutaw Place

SEP 16 1947 (Date received by registrar) (b) Huntington Williams M.D.

VS 150 DATA 9/17/47 Dr. C. [illegible] per Howard J. Mendis, M.S.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 1947, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 1947, to Sept 15 1947, and that I last saw him alive on Sept 15 1947.

Immediate cause of death Cardiovascular failure — Duration 3 days

Due to Coal operator employee

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Sept 12, 1947

Major findings of operation: Fracture of femur, R

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 11/2
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Sept 8 1947 9:30 A M
(c) Where did injury occur? 1305 John St Baltimore MD (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fell from chair to floor

23. Signature George P. Lemmo M. D.
Address Union Memorial Hosp Date signed 9-15-47

G55144

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G55144

170c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 55 min
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 731 Avondale Rd (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME James Thomas

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jennie

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 4/1/1908

8. AGE: Years 39 | Months 5 | Days 10 | If less than one day .....hr. .....min.

9. Birthplace Sparks, Md. (Town, county, and state)

10. Usual Occupation Mechanic & Chauffeur

11. Industry or business

FATHER
12. Name Elwood Thomas
13. Birthplace Sparks, Md.

MOTHER
14. Maiden Name Estella Nelson
15. Birthplace St. Marys County, Md

16 (a) Informant Jennie Thomas (Wife)
(b) Address 731 Avondale, Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/16/47 (month) (day) (year)
(c) Cemetery or crematory Stevenson Chapel
Location Sparks, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave

19 (a) SEP 16 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS. 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/11 1947, at 1 55 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Rupture of the Heart.

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-11-47 at 11 30 A.M.
(b) Where did injury occur? Hoffman Square Philadelphia Rd + Haven St
(c) Did injury occur at home, on farm, industrial place, in public place? Garage While at work? Yes
(d) Means of injury Truck fell on him

23. Signature ..... M.D. (Medical Examiner)
Date signed 9-12-47

55145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. C55145

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 644 Greenwillow
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 644 Greenwillow St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Widow

6 (b) Name of husband or wife Walter Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1941

8. AGE: Years	Months	Days	If less than one day
46	4	8	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housemaid
11. Industry or business

FATHER
12. Name James Taylor.
13. Birthplace Fredericksburg, Va.

MOTHER
14. Maiden Name Mintia W. Williams
15. Birthplace Md.

16 (a) Informant Annie Taylor
(b) Address 726 Cumberland St

17 (a) Burial (b) Date thereof 9-17-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory National
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) SEP 16 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/13 1947, at 10:45 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 9/8 1947, to 9/13 1947, and that I last saw h[illegible] alive on 9/11 1947

Immediate cause of death Pulmonary Edema

Due to Hypertensive C-V Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

	Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
Means of injury

23. Signature J. Paul Grant M.D.
Address 1511 N. Division Date signed 9/15/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

55146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1312

Registered No. C55146

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C55147

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 132 N. Glover St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 132 N. Glover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Theodore J. Rohleder

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Josephine Rohleder

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31-1870

8. AGE: Years 77 | Months 3 | Days 14 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Shipping Clerk

11. Industry or business Grain, Coal & Feed

FATHER
12. Name Thomas Rohleder
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Herman F. Rohleder
(b) Address 132 N. Glover St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 17-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director John F. Miller
(b) Address 2334 Jefferson St.

SEP 16 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14, 1947, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 25, 1947, to Sept 14, 1947, and that I last saw h[illegible] alive on Sept. 14, 1947.

	Duration
Immediate cause of death: Chronic Myocarditis	3 Mos.
Due to: Arteriosclerotic Heart Disease	5 Years
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benj. B. Moore, M.D. M. D.

Address 648 N. Luzerne Ave Date signed 9-15-47

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

55148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

✓ G55148 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Edgewood Nursing Home 19-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 309 North Fulton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EDNA L. KRIETE

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1881

8. AGE: Years	Months	Days	If less than one day
65	10	5	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Social Worker
11. Industry or business

FATHER
12. Name Edward N. Kriete
13. Birthplace Balto.

MOTHER
14. Maiden Name Anna M. DeBertin
15. Birthplace Balto.

16 (a) Informant Mr. J. R. Hines
(b) Address 6405 Pinehurst Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/17/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 16 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15, 1947, at 1:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 23 1947 to Sept. 14 1947, and that I last saw her alive on Sept. 13 1947.

Immediate cause of death	Duration
Cerebral Embolism.	5 hrs.
Due to detached thrombus of abdominal aorta	
Due to Operation - release of abdominal & pelvic adhesions	
Other Conditions Intestinal Obstruction & possible pulmonary infarct	

(Include pregnancy within 3 months of death)
Date of operation Aug. 19, 1947
Major findings of operation: Extensive adhesion of intestines & pelvic organs
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N. Clyde Marvel M. D.
Address 6 E. Biddle Street Date signed

+

Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

G55149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G55149

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1821 E. Baltimore St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1821 E. 33rd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HELENA LAUTENKLOS

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Conrad Lautenklos
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19, 1883

8. AGE: Years 64 | Months 2 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name - Sanner
13. Birthplace Germany

MOTHER
14. Maiden Name Mary -
15. Birthplace Unknown

16 (a) Informant Mrs. Amelia Magruder
(b) Address 4503 Hampnett Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/17/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 16 1947 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14, 1947 at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 15 1947 to Sept 14 1947 and that I last saw h[illegible] alive on Sept 14 1947.

Immediate cause of death: Metastatic carcinoma from left breast * — Duration: 2yrs.
Due to Abdominal
Due to Acute Cardiac failure (Acquired) — Duration: 2 day
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address 10 W. Madison St. Date signed 9-15-47 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V S 150

X

C55150

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 183

Registered No. C55150

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16-
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 208 N. Stricker Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Kenneth Lee

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/26/193

8. AGE: Years 15 | Months 6 | Days 15 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation School boy

11. Industry or business

FATHER
12. Name Sylvester Lee
13. Birthplace Md

MOTHER
14. Maiden Name Josephine Johnson
15. Birthplace Md.

16 (a) Informant Josephine Lee
(b) Address 208 N. Stricker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/47 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Md.

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Presbman St

19 (a) SEP 16 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 13, 1947, 6 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9/13/47 at 4:30 P. M.
(b) Where did injury occur Arundel Corporation Sand Bank, Brooklyn
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Drowning (waded into deep water)

23. Signature Howard J. McElroy M.D. Medical Examiner.
Date signed 9/15/47

VS 181

55151 429774

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

Registered No. C55151

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2430 3 Mc Culloh St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Owens.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	Col.	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-3-90

8. AGE: Years	Months	Days	If less than one day
57	7	12	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation hswf.
11. Industry or business

FATHER
12. Name Russel ?
13. Birthplace Md.

MOTHER
14. Maiden Name Rose ?
15. Birthplace

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 18, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Laura H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) SEP 16 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 1947 at 12 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-6- 1947 to 9-15- 1947, and that I last saw her alive on 9-15- 1947.

Immediate cause of death Insulin Coma — Duration 9 weeks

Due to administration of insulin at home for diabetes mellitus

Due to

Other Conditions ? cerebral vascular accident

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Grob M. D.

Address J N H Date signed 15 Sept 47

X

BALTIMORE CITY HEALTH DEPARTMENT

Registered No. C55152

55152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Reg. No. 055152

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Ruth Dudley Hilburn
(c) Hospital or institution: 1212 St. Paul Street
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) –

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 St. Paul Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth Dudley Hilburn

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Edward L.
6 (c) If alive, give age – years
7. Birth date of deceased (mo., day, yr.) July 11, 1892

8. AGE: Years	Months	Days	If less than one day
55	2	4	hr. min.

9. Birthplace Brooklyn, N.Y. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Dudley
13. Birthplace New York

MOTHER
14. Maiden Name
15. Birthplace England

16 (a) Informant Janice Simpson
(b) Address 1212 St. Paul Street

17 (a) Burial (Burial, cremation or removal) (b) Date thereof Sept. 17 (month) (day) (year)
(c) Cemetery or crematory Dashiell M. E. Cemetery
Location Jessup Md.

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

SEP 16 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

e MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15 1947, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to Sept 15 1947, and that I last saw h er alive on Sept 13 19 47.

Immediate cause of death	Duration
Cerebral Metastases	1 month
Due to Carcinoma of colon	1½ years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation May 1946
Major findings of operation: Carcinoma of colon
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alan Bernstein M. D.
Address 1109 N Calvert St Date signed 9/15/47

Balt 2

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

55153 121072

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 139a

Registered No. 55153

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 Mc Donogh St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl Slacum

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	Col	married

6 (b) Name of husband or wife James Slacum
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
42			hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Nurse
11. Industry or business

FATHER
12. Name George Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Matilda Brisco
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 16, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Brooklyn

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Edmondson Ave

19 (a) SEP 16 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 – 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-3- 1947 to 9-12 1947 and that I last saw h[illegible] alive on 9-11 1947.

Immediate cause of death	Duration
Massive Pulmonary Embolus Thrombosis.	
Due to Thrombophlebitis	
Due to Post Operation	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Pelvic Inflammatory Disease. Retroflexion 3° Fibroids.
of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert P. Darnall.
Address Johns Hopkins Hospital Date signed 9-12-47

G55154.

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH ✓ 937

Registered No. G55154

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address South Baltimore General Hosp.
(c) Hospital or institution:
1213 Light Street, Balto. 30, Md
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7305 Dunbrook Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ewing William Beatty

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	W. Dowed

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13, 1882

8. AGE: Years	Months	Days	If less than one day
65	1	3	hr. min.

9. Birthplace West Virginia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Robert Beatty
13. Birthplace

MOTHER
14. Maiden Name Jannie Teets
15. Birthplace

16 (a) Informant Mr. Ray A. Teets
(b) Address 7305 Dunbrook Ct., Dundalk

17 (a) Burial (b) Date thereof Sept. 19, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory White Rock
Location Elkphant, Pa.

18 (a) Funeral director Roland L. Baker
(b) Address 2112 Dundalk Ave.

19 (a) SEP 16 1947 (b) Huntingtown, Md.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16 1947, at 2:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 15 1947, to Sept. 16 1947, and that I last saw him alive on Sept. 16 1947.

Immediate cause of death Acute Congestive Failure — Duration 24 hrs.
Due to Hypertensive Cardio-Vascular Disease. — Duration Unknown
Due to — Duration
Other Conditions Senile Prostatic Hypertrophy (Include pregnancy within 3 months of death) — Duration
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles R. MacDonald M. D.
Address 1213 Light St. Date signed 9-16-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. If any item cannot be ascertained, state so. Do not use ditto marks. Do not abbreviate. Write the causes of death clearly and legibly. Use only standard abbreviations. Omit punctuation. Spell out full each word. Be sure that the cause, date, and place of death, and the statements of fact as to personal particulars are full, accurate, and correct; age is especially important. Physicians: please write the cause of death in terms of disease as distinguished from mode of dying, such as heart failure, asthenia, etc., and indicate whether natural, accidental, suicidal, or homicidal.

G55155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

77c

Registered No. G55155

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 929 Argyle Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 929 Argyle Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walker Fauntleroy Jr

3 (b) If veteran, name war

3 (c) Social Security Account No. 228-03-9715

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife. Julia Fauntleroy
6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) 9-20-01

8. AGE: Years	Months	Days	If less than one day
46	11	24	hr. min.

9. Birthplace Langston, Va. (Town, county, and state)
10. Usual Occupation Fisherman
11. Industry or business Lewes, Del.

FATHER
12. Name Walter Fauntleroy
13. Birthplace Va

MOTHER
14. Maiden Name Priscilla Williams
15. Birthplace Va.

16 (a) Informant Julia Fauntleroy
(b) Address 927 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-17-47 (month) (day) (year)
(c) Cemetery or crematory
Location Langston, Va.

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Ave.

19 (a) SEP 16 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH September 14, 1947, at 7 a.m. P.M.

21. I certify that I took charge of the remains described above, held an Autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Acute Alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Royer M.D. Medical Examiner
Date signed 9/19/47

X

C55156

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. C55156

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 75 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 49 Norris Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Bordley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years: 72 | Months | Days | If less than one day: hr. min.

9. Birthplace Greensville Md
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name William J Bordley
13. Birthplace Greensville Md

MOTHER
14. Maiden Name Fannie Bordley
15. Birthplace Gracenville Md

16 (a) Informant Mary Evelin Young
(b) Address 49 Norris Lane Dundalk Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 16th 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetary
Location Brooklandville Md

18 (a) Funeral director Elroy O Wilson
(b) Address 1005 Brantley Ave Huntington Park Md

19 (a) SEP 16 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13 1947, at 7 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7 1947 to Sept 13 1947, and that I last saw h alive on Sept 13 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Pneumonia Lobar	
Due to Meningitis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sidney L Sachs M. D.
Address Univ Hosp. Date signed 9/13/47

VS 190

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G55157

Please write the causes of death clearly and legibly. Physicians: please state correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkins Ave
(c) Hospital or institution:
Saint Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Frederick
(c) City or town Emmitsburg Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Edith Warthen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/10/83

8. AGE: Years	Months	Days	If less than one day
64	6	25	hr. min.

9. Birthplace Emmitsburg, Maryland
(Town, County, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name Thomas Warthen
13. Birthplace Md, Maryland

MOTHER
14. Maiden Name Louise O'Toole
15. Birthplace Md, Maryland

16 (a) Informant

(b) Address

17 (a) Burial (b) Date thereof Sept, 19
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St Anthony
Location Emmitsburg Md.

18 (a) Funeral director Jol Lohmeyer & Bro.

(b) Address 1124 W. North Ave.

19 (a) Date received SEP 16 1947 (b) Registrar Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/15 1947, at 10:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/6 1947, to 9/16 1947, and that I last saw h~~e~~r alive on 9/15 1947.

Immediate cause of death Acute Pulmonary Edema

Due to Left Ventricular Failure
Hypertensive C-V Disease

Due to Blood Dyscrasia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulmonary Edema, Splenomegaly

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James C. Hamill M. D.

Address St Agnes Hosp Date signed 9/16/47

X

G55158

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G55158

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 Rogers Ave.
(c) Hospital or institution:
Methodist Home for Aged 27-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 Rogers Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Ann Milby Elizabeth Ann Milby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Dr. Arthur R. Milby
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1867

8. AGE: Years	Months	Days	If less than one day
80	6	10	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Wesley Brownley
13. Birthplace Mathews County, Va.

MOTHER
14. Maiden Name Elizabeth Ann Auld
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. William A. Milby
(b) Address 3614 Hillsdale Road

17 (a) Burial (b) Date thereof Sept. 17, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Leslie L. Amoreau
(b) Address 5510 Liberty Heights Ave.

19 (a) SEP 16 1947 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 13 Sept. 1947, at 11:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to Arteriosclerotic Cardio-Vascular Disease.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer M.D.
Medical Examiner.
Date signed 14 Sept. 1947

X

G55159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. G55159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4515 Garrison Blvd
(c) Hospital or institution: Rainbow Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4515 Garrison Blvd 10
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna L. D. Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) ~~Single~~, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Wm. H. Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 11-1867

8. AGE: Years 79 | Months 11 | Days 14 | If less than one day hr. min.

9. Birthplace Phila Pa
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name Emma
15. Birthplace

16 (a) Informant Wm. H. Thomas Jr.
(b) Address 5111 York Road

17 (a) Burial (b) Date thereof Sept 17-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director J. Ostrander & Son
(b) Address 2300 N. Charles St

19 (a) SEP 16 1947 (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 1947 at 10:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/26 1946 to 9/15 1947 and that I last saw her alive on 9/6 1947

Immediate cause of death Carcinoma of Rectum — Duration 6 mos.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. B Seale M.D.
Address 514 Medical Arts Date signed 9/16/47

X

355160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V 157E

Registered No. C55160

Please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State NJ (b) County
(c) City or town Tuesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Main St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Niederer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-16-31

8. AGE: Years 16 | Months — | Days — | If less than one day — hr. — min.

9. Birthplace N J (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Otto Niederer
13. Birthplace Switzerland

MOTHER 14. Maiden Name Catherine Schuster
15. Birthplace New Jersey

16. (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Tuesville Methodist
Location N J

18 (a) Funeral director Arand W Lash
(b) Address 814 E 36 St

19 (a) SEP 16 1947 (Date received by Local Registrar) (b) Huntington Williamsport, Md. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-15-47, at 10:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-28 1947, to 9-15 1947, and that I last saw her alive on 9-15-1947.

	Duration
Immediate cause of death: RIGHT HEART FAILURE	7 DAYS
Due to: ANASTOMOSIS BETWEEN END RT SUBCLAVIAN & SIDE RT PULMONARY	2 WKS
Due to: ARTERIES	
DUE TO - TETRALOGY OF FALLOT	LIFE
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation 8-29-47

Major findings of operation: TETRALOGY OF FALLOT

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard C. Clay M. D.
Address Johns Hopkins Hosp Date signed 9-16-47

X

G55161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G55161

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 933 E. Preston street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10-1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ---
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 933 E. Preston
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA G. DOBBS

3 (b) If veteran, name war --
3 (c) Social Security Account No. ---

4. Sex: Female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Claude Dobbs
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 21, 1881
8. AGE: Years 66 | Months 3 | Days 23 | If less than one day 24 hr. min.
9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Philip H. McAleer
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Catherine J. Kelleher
15. Birthplace Ireland

16 (a) Informant Mr. Claude Dobbs
(b) Address 933 E. Preston street

17 (a) Burial (b) Date thereof 9/18/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas J. Ernest Son Inc
(b) Address 4 & N. Mt. Royal Ave

19 (a) SEP 16 1947 (Date rec'd by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14 19 47 at 5.30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-Sept 1947 to 14-Sept 1947 and that I last saw h[illegible] alive on 14-Sept 1947.

Immediate cause of death: Lobar Pneumonia Right — Duration: 8 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas W. Edwards M. D.
Address 2746 Tree Alameda Date signed 15 Sept 47

VS 150

G55162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164a

Registered No. G55162

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 3628 E Fayette St. (Ward: 26)
(c) Hospital or institution:
If dead: Baltimore City Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 24
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3608 Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Antoni Urbanowski

3 (b) If veteran, name war

3 (c) Social Security Account No. 314-03-3167

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband~~ or wife Stanislawa

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Aug. 12-1882

8. AGE: Years	Months	Days	If less than one day
65	1	3	____ hr. ____ min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Frank Urbanowski
13. Birthplace Poland

MOTHER
14. Maiden Name Sofila Mufka
15. Birthplace Poland

16. (a) Informant Stanislawa Urbanowski
(b) Address 3608 Fayette St.

17 (a) Burial (b) Date thereof 9-19-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Holy Rosary
Location Baltimore, Md.

18 (a) Funeral director George A. Weber
(b) Address 705 S. Linn St.

19 (a) SEP 16 1947 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 15 1947, at 5:20 P.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to hanging

Other Conditions Despondency
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-15-47 at 4:30 P.M.(?)
(b) Where did injury occur? 3628 E. Fayette St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury: Rope hanging from transom

23. Signature Earl L. Kay M.D.
Medical Examiner.
Date signed 9-16-47

G55163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G55163 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3129 Clearview Ave
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-14 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3129 Clearview Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Constance Makowiecki

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Vincent
6 (c) If alive, give age Decd years

7. Birth date of deceased (mo., day, yr.) March 16-1874

8. AGE: Years	Months	Days	If less than one day
73	5	29	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr. Edward Makowiecki (Son)
(b) Address 3129 Clearview Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-19-47 (month) (day) (year)
(c) Cemetery ~~xxxxxx~~ St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A Weber
(b) Address 705 South Ann Street

19 (a) SEP 16 1947 (Date rec'd by registrar) (b) Huntington Wilson Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH September 15 1947, at 11 40 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Sept. 15, 1947, and that I last saw her alive on Sept. 15 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	20 hrs.
Due to Hypertension and Cardio-vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nathan Janney M. D.
Address 7101 Harford Rd. Date signed 9/16/47

55164 AB-113813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 55164

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3300 Schuch street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Rosenberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12 1896

8. AGE: Years 50 | Months 11 | Days 27 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Jacob Stranger
13. Birthplace Balto

MOTHER 14. Maiden Name Unknown
15. Birthplace ?

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 17 (c) (year)
(c) Cemetery or crematory Chesterholme Cem
Location Ormeldy

18 (a) Funeral director Jones & Co
(b) Address 2432 Reisterstown R

19 (a) SEP 16 1947 Waiting for Williams Certificate

MEDICAL CERTIFICATION AM

20. DATE OF DEATH Sept-15- 1947, at 7.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-14- 1947, to 9-15- 1947, and that I last saw h Dr alive on 9-15- 1947

Immediate cause of death
Coma
Due to Diabetes Mellitus
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: A short

Duration
3- 4 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J E Robinson Jr M. D.
Address Balt. City Hosp Date signed 9/15/47

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

55165

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G55165

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Wesley Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Havre de Grace, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. Warren Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME JOHN G. SCOTT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Baby

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 9, 1945

8. AGE: Years 2 | Months 6 | Days 7 5 | If less than one day ... hr. ... min.

9. Birthplace Havre de Grace, Md
(Town, county, and state)

10. Usual Occupation Baby

11. Industry or business —

FATHER
12. Name George A. Scott
13. Birthplace Carolina County, Va

MOTHER
14. Maiden Name Mary V. Jackson
15. Birthplace Havre de Grace Md

16 (a) Informant Mrs. George Scott
(b) Address Warren St, Havre de Grace Md

17 (a) Burial (b) Date thereof 9 17 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. James A.M.E.
Location Havre de Grace, Md

18 (a) Funeral director Elmer E. Bullock
(b) Address 256 Lewis St. Havre de Grace Md

SEP 17 1947
(a) (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 14 1947, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-14 1947, to 9-14 1947, and that I last saw h~~im~~ alive on 9-14 1947.

Immediate cause of death: cardio-respiratory failure
Due to: Meningitis
Due to: (Etc)
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration: ... over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. A. Galenbeimer M. D.
Address ~~Wesley~~ Wesley Hosp Date signed 9-14-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163B

G55166 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4306 Valley View Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4306 Valley View Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Dial

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	Widowed

6 (b) Name of husband or wife Candler Dial
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 20, 1891

8. AGE: Years	Months	Days	If less than one day
56	07	27	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Edward F. Holden
13. Birthplace Ireland

MOTHER
14. Maiden Name Lily Richmond
15. Birthplace Baltimore, Md.

16 (a) Informant Ralph Dial
(b) Address 5208 Belleville Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director John C. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) SEP 17 1947 (Date rec'd by registrar) (b) Interring for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 1947, at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1947 to Sept 16 1947 and that I last saw her alive on Sept 15 1947

Immediate cause of death Heart failure — Duration 2 months 6 ds

Due to Rheumatic fever and thyrotoxicosis — Duration (Several childhood)

Due to

Other Conditions Myocardial damage with terminal fibrillation

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice I. Hurt, M.D.
Address 1436 N Kenwood Ave Date signed 9/16/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V S 150

G55167 BC# #56336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓104a

Registered No. G55167

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1113 Park Avenue (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Sarah Ann Talley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1946

8. AGE: Years	Months	Days	If less than one day
1		4 3	.....hr. .....min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation.....
11. Industry or business

FATHER
12. Name James Talley
13. Birthplace N.C.

MOTHER
14. Maiden Name Audrey Willis
15. Birthplace Norfolk Va.

16 (a) Informant Audrey Willis
(b) Address 1113 Park Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-18-47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Cemetery
Location.....

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 SEP 17 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION OS

20. DATE OF DEATH 9-13- 1947 at 10 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Upper respiratory infection

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Earl L Royster M.D. Medical Examiner
Date signed 9-15-47

X

G55168 — 113567

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 4/12 B

Registered No. G55168

Please write the causes of death clearly and legibly. Physicians: please supply information requested. Item 20 is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 10 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 835 N. Wolf ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bessie Harley

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Andrew
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March -26 -1887

8. AGE: Years	Months	Days	If less than one day
60	5	19	hr. min.

9. Birthplace MD. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Robert Campbell (D)
13. Birthplace VA.

MOTHER
14. Maiden Name Martha Toles (D)
15. Birthplace MD.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 18-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. Co. Md.

18 (a) Funeral director Bafront Magnis & Knight
(b) Address 727 Pasquito St.

19 (a) 9-17-1947 (Date rec'd by Registrar) (b) Huntington Williams M.D.

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14 - 1947, at 7.35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 4-1947, to Sept. 14-1947, and that I last saw her alive on Sept. 14-1947

Immediate cause of death	Duration
Hyperinsulinism	1 da
Due to Diabetes mellitus	7 yrs
Due to	
Other Conditions Tuberculosis of lungs, far advanced (Include pregnancy within 3 months of death)	6 mo +

Date of operation
Major findings of operation:
of autopsy: see above

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph J. Brown Jr. M. D.
Address Bal. City Hosp. Date signed 9-15-47

61

55169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. C55169

please write the causes of death clearly and legibly. Physicians: please see that all items are correctly answered. Be sure to state correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1531 N Caroline St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Chinskey (Vlchinskey)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	married

6 (b) Name of husband or wife Frances
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 87

8. AGE: Years	Months	Days	If less than one day
76			hr. min.

9. Birthplace Lith (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name George Vlchinskey
13. Birthplace Lith

MOTHER
14. Maiden Name ?
15. Birthplace Lith

16 (a) Informant Frances Vlchinskey
(b) Address 1534 N Caroline St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 18-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Joseph Kasmukas
(b) Address 60 E Washington St

19 (a) Sept 17 1947 (b) Signature of registrar Huntington Williams M.D.
Date rec'd by Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/15 1947, at 9:45 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 9/15 1947 to 9/15 1947 and that I last saw h alive on 9/16 1947.

Immediate cause of death	Duration
Pulmonary edema	10 min.
Due to Intestinal obstruction	4 days
Due to strangulated L. inguinal hernia	4 days
Other Conditions Ca of rectum Ca of prostate	

(Include pregnancy within 3 months of death)

Date of operation 9/15/47
Major findings of operation: Incarcerated Left Inguinal Hernia & Obstruction
of autopsy: Pulmonary edema

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury None
23. Signature Harold Lussman M.D.
Address Sinai Hospital Date signed 9/16/47

VS. 150

Carl V. Boyer M.D.

G55170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓186a

Registered No. G55170

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1029 N. Carrollton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oscar M. Tucker

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 15, 1947, at 9 a. 55 M.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1893

8. AGE: Years	Months	Days	If less than one day
53 54	9	5	hr. min.

9. Birthplace Alabama (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Tucker
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs Emily Tucker
(b) Address 523 N. Paca Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-18-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) SEP 17 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Shock

Due to Multiple fractures + Ruptured spleen + Diaphragm

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9/15/47 at 7 05 a. 25/6 M.
(b) Where did injury occur? Boundary Sand & Gravel Co., Pier No. 3, Orask St.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes.
(d) Means of injury Jumping [illegible] on railroad car track, approx. 35' to pier.

23. Signature Earl M. Gosh M.D.
Medical Examiner
Date signed 9/15/47

VS 151

55171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 192a

G55171 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edmondson Avenue
(c) Hospital or institution:
Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1822 E Eager
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Colored	Married

6 (b) Name of husband or wife Hunter Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-29-05

8. AGE: Years	Months	Days	If less than one day
42		13	5 hr. min.

9. Birthplace North Carolina
(Town, county, and state)
10. Usual Occupation H. W
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace North Carolina

MOTHER
14. Maiden Name Jarmin
15. Birthplace North Carolina

16 (a) Informant Hunter Johnson
(b) Address 1827 E Eager

17 (a) Burial (b) Date thereof 9-17-49
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

SEP 17 1947
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-13 1947 at 5:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-13 1947 to 9-13 1947 and that I last saw her alive on 9-11 1947

Immediate cause of death Right Heart Failure — Duration 2 hrs

Due to Aortic Insufficiency — 3

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William R Best M. D.
Address Mercy Date signed 9-13-49

VS 150

PRINT ENTIRE ENTRIES, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164c

Registered No. G55172

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7 Calvert St.
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 517 Cathedral Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Eng-Quong Sun (ENG QUONG SUN)

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Chinese	Single

6 (b) Name of husband or wife Single

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) About-1912

8. AGE: Years	Months	Days	If less than one day
Abt-35	—	—	hr. min.

9. Birthplace probably San Francisco
(Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business Restaurant

FATHER
12. Name Could not ascertain
13. Birthplace " " " "

MOTHER
14. Maiden Name Could not ascertain
15. Birthplace " " " " "

16 (a) Informant Mr. Bok Ark (Friend)
(b) Address 716 Southwood-City 16

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sep-17-47 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Bucks Co. Md.

18 (a) Funeral director Stewart Mortuary
(b) Address 1080 N. Howard Ave.

19 (a) SEP 17 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 15, 1947, at 12 Noon M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet wound of brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-15-47 at Between 9.30 am & 11 30 A M.
(b) Where did injury occur? 517 Cathedral St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fire-arm.

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 9/15/47

55173

BALTIMORE CITY HEALTH DEPARTMENT X
CERTIFICATE OF DEATH ✓ 587

Registered No. 55173

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + Saratoga Sts.
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hour.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Charles
(c) City or town Waldorf, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Stone ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19, 1923

8. AGE: Years	Months	Days	If less than one day
84	4	26	hr. min.

9. Birthplace Washington, D.C.
(Town, county, and state)
10. Usual Occupation Truck driver
11. Industry or business

FATHER
12. Name Unknown (orphan)
13. Birthplace

MOTHER
14. Maiden Name Unknown (orphan)
15. Birthplace

16 (a) Informant William Stone
(b) Address (Son) Waldorf Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-18-47 (month) (day) (year)
(c) Cemetery or crematory Holy Face
Location Great Mills, Md.

18 (a) Funeral director C.B. Robinson
(b) Address Leonardtown Md

19 (a) SEP 17 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14 1947, at 7:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 14 1947 to Sept. 14 1947, and that I last saw h[illegible] alive on Sept. 14 1947.

Immediate cause of death	Duration
Acute heart failure	
Due to Rheumatic Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Johnson M. D.
Address Mercy Hospital Date signed 9/19/47

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 159

3174 B# B 88596

Registered No. G55174

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1511 Union Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Hoot

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male

5. Color or race white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/4/47

8. AGE: Years 0 Months 0 Days 0 If less than one day 1 hr. 26 min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Clarence Hoot
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Florence Killmon
15. Birthplace Washington D.C.

16 (a) Informant Florence Hoot
(b) Address 1511 Union Ave. Balto. Md

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 10 1947 Commissioner of Health

18 (a) Funeral director
(b) Address

19 SEP 17 1947 (Date filed by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4 1947 at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 4 1947 to Sept 4 1947 and that I last saw h[illegible] alive on Sept 4 1947

Immediate cause of death [illegible] — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Hospital Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

55175

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √55E

G55175 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1311 E. Orleans St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1311 E. Orleans St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country Colored

3 (a) FULL NAME Dorothy May Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 22. 1930

8. AGE: Years 16 | Months 10 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation School

11. Industry or business

FATHER 12. Name Archie Smith
13. Birthplace Maryland

MOTHER 14. Maiden Name Bertha Edwards
15. Birthplace Maryland

16 (a) Informant Bertha Edwards
(b) Address 1311 E. Orleans St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 17, 1947 (month) (day) (year)
(c) Cemetery or crematory Marley Meth Epis. Cem.
Location Marley Neck Md

18 (a) Funeral director Chas. B. Wilson
(b) Address 1015 Biddle St

SEP 17 1947 (Date rec'd by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13 1947, at 9 40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-12 1947, to 9-13 1947, and that I last saw her alive on 9-13 1947.

Immediate cause of death	Duration
Due to pulmonary tuberculosis	4 mo
Due to sarcoma of right leg	2 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Roland W. McDaniel M. D.
Address 817 N. Caroline St Date signed 9-17-47

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

55176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193a

G55176 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12 S Schroeder St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs.) mos., or days) 15

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 12 S Schroeder St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex F

5. Color or race Col

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 16 1908

8. AGE: Years	Months	Days	If less than one day
48	10	28	hr. min.

9. Birthplace SC (Town, county, and state)

10. Usual Occupation H W

11. Industry or business

FATHER
12. Name James Jones
13. Birthplace S C

MOTHER
14. Maiden Name Mary Liby
15. Birthplace S C

16 (a) Informant Drew Harris
(b) Address 1350 Carroll Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 16 47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co., Md.

18 (a) Funeral director Isaac L Brust Son
(b) Address 101 W. Montgomery St.

SEP 17 1947 (Date rec'd by registrar) (b) Huntington Williamsport, Md.

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MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13 1947 at 9 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-8 1947 to 9-13 1947 and that I last saw h[illegible] alive on 19

Immediate cause of death	Duration
Cardiac failure	
Due to Acute Myocarditis	5
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. F. Haleker M.D.
Address 1115 Park Ave Date signed 9/17/47

055177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 055177

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 416 Mt. Holly St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town, write RURAL and give name)
(d) Street No. 416 Mt Holly St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Rebecca Hughes

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: George G. Hughes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 25, 1862

8. AGE: Years 85 | Months 5 | Days 20 | If less than one day 21 hr. min.

9. Birthplace Catoctin, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name David Heim
13. Birthplace Redlands, Md.

MOTHER
14. Maiden Name Mary Smith
15. Birthplace Cumberland, Md.

16 (a) Informant Mr. Vernon Hughes
(b) Address 416 Mt. Holly St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 SEP 17 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 1947 at 9:45 P M

21. I certify that I took charge of the remains described above, held an Aut & Insp. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G Stafford M.D. (Medical Examiner)
Date signed Sept 16, 1947

Correct age in quarantine diseases. Registrar must write name. Physician must write cause of death clearly and legibly.

5178

BCH 688791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

G55178
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1140 Ridgely Street
(c) Hospital or institution: home
(d) Length of stay in hospital or inst. (yrs., mos., or days) -
(e) Length of stay in Baltimore (yrs., mos., or days) -

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1140 Ridgely Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country -

3 (a) FULL NAME Robert Lee Simmont

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 16, 1947

8. AGE: Years	Months	Days	If less than one day
-	-	-	13/4 hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation -
11. Industry or business -

FATHER
12. Name George W. Simmont
13. Birthplace Baltimore

MOTHER
14. Maiden Name Sadie Markell
15. Birthplace Baltimore

16 (a) Informant Mr. George W. Simmont
(b) Address 1140 Ridgely Street

17 (a) Burial (b) Date thereof Sept. 17
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Moreland Memorial Park

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) SEP 17 1947 (b) Huntington Williams M.D.
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16 19 47 at 7:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 16 1947, to Sept 16 1947, and that I last saw h alive on 19 .

Immediate cause of death	Duration
Acute Fatis	1/2 hr
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hans Gleesman M. D.
Address 2687 Madison Ave Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

55179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 82a

G55179 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2824 Pennwood Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2824 Pennwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Gail

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Harry.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 17. 47 84

8. AGE: Years 80 | Months 11 | Days 27 | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Aulbach
13. Birthplace Germany.

MOTHER
14. Maiden Name Cath. ?
15. Birthplace Germany

16 (a) Informant Mr. Carl Gail
(b) Address 2824 Pennwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 17. 47 (month) (day) (year)

(c) Cemetery or crematory Immanuel
Location Dundalk Lane

18 (a) Funeral director L. HECKMANN & SON
(b) Address 6067 HARFORD Rd.

19 SEP 17 1947 (Date received by Registrar) (b) Huntingtown Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 7, 1947 to Sept. 14, 1947 and that I last saw h[illegible] alive on Sept. 13 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	6 days.
Due to Cerebral Arteriosclerosis	7 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ida Immanuels
Address Redwood Cat Hosp Date signed 9/17/47 M. D.

55180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C55180

Correct age if apparently important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A.
(b) Street address 3157 Keswick Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3157 Keswick Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Reinhardt

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-8340

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary A Rinehart
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Jan 23, 1885

8. AGE: Years	Months	Days	If less than one day
62	7	24	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired Brakeman
11. Industry or business Penna R.R.

FATHER
12. Name William Rinehart
13. Birthplace Maryland

MOTHER
14. Maiden Name Lena Lequincy
15. Birthplace Maryland

16 (a) Informant Mary A Rinehart
(b) Address 3157 Keswick Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 19/47 (month) (day) (year)
(c) Cemetery or crematory Loreland Park
Location Baltimore Md

18 (a) Funeral director Unsworth & Donovan
(b) Address 3615-17 Christmont Ave.

19 (a) Date rec'd by registrar SEP 19 1947 (b) Huntington Williams M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/16 1947, at 6:25 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. S. Williams M.D.
Medical Examiner.
Date signed 9/17/47

G55181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G55181

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos.,~~ or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County [redacted] Baltimore
(c) City or town Towson 4
(If outside city or town limits, write RURAL and give town)
(d) Street No. 500 Virginia Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward S. Suter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, ~~married, widowed, or divorced~~ single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 9-20-1890

8. AGE: Years 56 | Months 11 | Days 25 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Alexander Suter
13. Birthplace Washington D.C.

MOTHER
14. Maiden Name Emily Jenkins
15. Birthplace Louisiana

16 (a) Informant Miss Emma E. Ehrenfeld
(b) Address 500 Virginia Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 17/47 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Prospect Hill
Location Towson, Md.

18 (a) Funeral director Ehrenfeldt & Donovan
(b) Address 3615-17 Chestnut Ave

19 SEP 17 1947 (Date rec'd by registrar) (b) Huntingtown Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-14 1947, at 4:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-3 1947, to 9-14 1947, and that I last saw him alive on 9-14 1947.

Immediate cause of death	Duration
Generalized metastasis from Carcinoma	
Due to Carcinoma of Gall Bladder	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 8-4-47

Major findings of operation: Carcinoma of Gall Bladder & involvement of Duodenum over.

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry E. Bakemeier M.D.
Address Union Memorial Hosp. Date signed Sept 17 1947

PHYSICIAN
Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

55182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G55182 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 226 S. Gilmor St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 226 S. Gilmor St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Gertrude McCann

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife James P. McCann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8, 1874

8. AGE: Years	Months	Days	If less than one day
73	4	7	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name Henry Geisel
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Jacob
15. Birthplace Germany

16 (a) Informant Glydas Galinskas
(b) Address 226 S. Gilmor St.

17 (a) Burial (b) Date thereof Sept. 18, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Frederick A. Cole
(b) Address 1200 N. Lombard St.

1947 SEP 17 (b) Huntington Williams M.D.
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15, 1947 at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1945 to Sept 15 1947, and that I last saw h[illegible] alive on Sept 14 1947

Immediate cause of death Respiratory failure — Duration
Due to Arteriosclerotic and hypertensive Cardiovascular renal disease
Other Conditions Hemiplegia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. Sborofsky M.D.
Address 601 N. Monroe St. Date signed 9/16/47 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G55183 Registered No. 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 623 N. Bradford St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-3
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yr 7 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and
(d) Street No. 623 N. Bradford
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Victoria Baker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	col	widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) —

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace Whitmire S.C.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

MOTHER / FATHER
12. Name Simms Epps
13. Birthplace Va
14. Maiden Name unknown
15. Birthplace D.C

16 (a) Informant Sarah Moore
(b) Address 623 N Bradford St

17 (a) Removal (b) Date thereof Sept 17 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Newberry S. Carolina

18 (a) Funeral director Mr. Pitts Elliott Dept
(b) Address 1129 N. Caroline St.

19 (a) (b)
Rec'd by registrar Huntington Williams M.D.
SEP 17 1947
VS 150

MEDICAL CERTIFICATION 30

20. DATE OF DEATH Sept 13 1947 at 12 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 5 1947 to Sept 13 1947 and that I last saw h alive on Sept 11 1947

Immediate cause of death — Duration

Cerebral Hemorrhage 8dys
Due to Arterio Sclerosis
Due to Hypertension

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature V. Edward Fisher
Address 1642 E Monument Date signed 9/13/47

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G55184 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1929 Fleet St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred T. Marciszonek (MARSONEK)

3 (b) If veteran, name war: II World War
3 (c) Social Security Account No.: Single

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	217-07-7932

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 2 - 1913

8. AGE: Years	Months	Days	If less than one day
34	1	13	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Machinist Helper
11. Industry or business Bethlehem Key Highway

FATHER
12. Name Joseph Marcisszonek
13. Birthplace Poland

MOTHER
14. Maiden Name Stella Olencienicz
15. Birthplace Poland.

16 (a) Informant Josephine Baccala
(b) Address 19 N. Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 19-47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto. Co.

18 (a) Funeral director Wm. J. Fialkowski
(b) Address 2007 Eastern ave

19 (a) SEP 19 1947 (Date rec'd by registrar) (b) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH September 15 1947, at 7 20 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy / Inspection or Inquiry, find that said deceased came to Loss death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary artery disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil H. Ryan M.D.
Medical Examiner
Date signed 9-15-47

X

G55185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G55485 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 37 days
(e) Length of stay in Baltimore (yrs., mos., or days): 37 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Pa. (b) County:
(c) City or town: Philadelphia
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 5410 Aldine Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: Barnes Compton Anderson

3 (b) If veteran, name war: —

3 (c) Social Security Account No.: 180-14-2566

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Daisy White Anderson
6 (c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): March 9, 1885

8. AGE: Years	Months	Days	If less than one day
62	6	8	____ hr. ____ min.

9. Birthplace: Deal Island, Md.
(Town, county, and state)
10. Usual Occupation: Chief Mate
11. Industry or business: Seafarer

FATHER
12. Name: James Anderson
13. Birthplace: Deal Island, Md.

MOTHER
14. Maiden Name: Elizabeth Wilson
15. Birthplace: Md.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/20/47 (month) (day) (year)
(c) Cemetery or crematory: Philadelphia
Location: Philadelphia Pa.

18 (a) Funeral director: Lilly & Zeiler, Inc.
(b) Address: 403 S. Wolfe St. Balto, Md.

19 (a) SEP 17 1947 (Date rec'd by registrar) Livingston Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 17 19 47 at 8:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 11 1947, to Sept. 17 19 47, and that I last saw him alive on Sept. 17 19 47.

Immediate cause of death	Duration
(1) Cardiac hypertrophy (left side)	2 yrs.
(2) Atherosclerosis of aorta Due to severe with ulceration	2 yrs.
(3) Arteriolar nephrosclerosis Due to left	2 yrs.
(4) Hydronephrosis, right	2 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation: 8-21-47
Major findings of operation: Benign prostatic hypertrophy
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Henry Schoore, Jr. Asst Surgeon M. D.
Address: US Marine Hospital Baltimore, Md. Date signed: 9/17/47

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

Dr. Mc Elwain
31 E. North Ave.

BALTIMORE CITY HEALTH DEPARTMENT

G55186

CERTIFICATE OF DEATH 477

Registered No. G55186

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2328 E. North Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2328 E. North Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen C. Mc Nally

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Daniel Mc Nally
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 3, 1878

8. AGE: Years	Months	Days	If less than one day
68	9	13	hr. min.

9. Birthplace Kaiper, West Virginia
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name John Brophy
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Robinson
15. Birthplace Ireland

16 (a) Informant Patrick Mc Nally
(b) Address 2328 E. North Avenue

17 (a) Burial (b) Date thereof 9-19-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

(Date received by registrar) (b) Huntington for Williamsville

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16th, 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 13 1947 to Sept 16 1947 and that I last saw her alive on Sept 13 1947

Immediate cause of death	Duration
Myocardial Insufficiency (a)	1 hr.
Due to Carcinoma. Left Lung	2 mo
Due to —	
Other Conditions. Diagnosed by X-ray as Tuberculosis	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. B. McElwain
Address 316 North Ave Date signed 9-16-47 M. D.

V S 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47c

G55187 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood & Green Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Hampstead
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SHAFFER, ~~HARRY~~ HOWARD M.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	married

6 (b) Name of husband or wife Eleanor M Shaffer
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Dec 8-1894

8. AGE: Years	Months	Days	If less than one day
52	9	8	..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Barber
11. Industry or business

FATHER
12. Name John W Shaffer
13. Birthplace Maryland

MOTHER
14. Maiden Name Alice L Rinaman
15. Birthplace Maryland

16 (a) Informant Mrs Edward M Shaffer
(b) Address Hampstead Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-19-47 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Carroll Co Md

18 (a) Funeral director Edw L Tipton
(b) Address Hampstead Md

19 (a) ..... (Date received by registrar) (b) Huntington Nthwest Baltimore

SEP 19 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 1947 at 5:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 14 19.. to Sept 16 1947, and that I last saw h.. alive on Sept 16 1947

Immediate cause of death resp. failure

Due to pneumonitis

Due to Bronchogenic Carcinoma

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R C Duvall Jr M. D.
Address Univ Hosp Date signed Sept 16

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55188

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G55188 Registered No. 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts.
(c) Hospital or institution:
University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Manchester
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MABEL ANDERSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Wm. P. Anderson
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) 2-13-1891

8. AGE: Years	Months	Days	If less than one day
56	7	4 3	hr. min.

9. Birthplace Minnesota (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Putnam
13. Birthplace Illinois

MOTHER
14. Maiden Name Josepheine Leighton
15. Birthplace Minnesota

16 (a) Informant Wm. P. Anderson
(b) Address Manchester Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-19-47 (month) (day) (year)
(c) Cemetery or crematory Pleasant Grove
Location Balto Co - Md

18 (a) Funeral director Edw C Tipton
(b) Address Hampstead, Md

19 (a) (Date received by registrar) (b) Huntington Williams Md Registrar

SCD 1950
SVS 15b

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The space for information should be carefully supplied. The

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16 1947 at 10:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 16 1947 to Sept 16 1947 and that I last saw her alive on Sept 16 1947

Immediate cause of death	Duration
respiratory failure	
Due to Cerebral Vascular Accident	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. C. Duvall Jr. M. D.
Address Univ. Hosp. Date signed Sept 17

X

G55189 BALTIMORE CITY HEALTH DEPARTMENT G55189
CERTIFICATE OF DEATH 94a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp. 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 309 N. Bruce St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elmer Brooks

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years 44 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name William Brooks
13. Birthplace St. Marys Co. Md.

MOTHER
14. Maiden Name Susie Penn
15. Birthplace Md

16 (a) Informant Bessie Fenwick
(b) Address 309 N. Bruce St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. Co. Md

18 (a) Funeral director Metropolitan Funeral Home
(b) Address 947 N. Mount St.

19 SEP 17 1947 (Date rec'd by registrar) Waiting for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 14 1947, at 5:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Edward Reyer M.D. Medical Examiner.
Date signed 9-15-47

VS 191

G55190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G55190 Registered No. 1639

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 758 Carroll Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edith L. Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Francis A. Davis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1926

8. AGE: Years	Months	Days	If less than one day
22	7	5	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Samuel E. Conner
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Lena E. Frank
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Francis Davis
(b) Address 758 Carroll St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-18-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave

18 (a) Funeral director Harry H. Wilkes
(b) Address 4101 Edmondson Ave

19 (a) Huntington Williams M.D. Registrar (Date rec'd by registrar)

VS 191

MEDICAL CERTIFICATION

05

20. DATE OF DEATH September 15 1947, at 6 a. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Fluoride Poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-15-47 at 2 A. M.
(b) Where did injury occur? 758 Carroll St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Ingestion of sodium fluoride

23. Signature Howard J. Andrews M.D. Medical Examiner.
Date signed 9-15-47

G55191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G55191 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 182 Ruxton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 60

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1821 Ruxton Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Politzer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Jacob Politzer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 13 1867

8. AGE: Years	Months	Days	If less than one day
80	0	3	hr. min.

9. Birthplace Germany (town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jos Erlebacher
13. Birthplace Germany

MOTHER
14. Maiden Name Nanette Gelbstein
15. Birthplace Germany

16 (a) Informant Jerome Politzer
(b) Address 182 Ruxton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 18 47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Belair Ave

18 (a) Funeral director J. Lehrer & Co
(b) [illegible] 1947 2422 Eastern Ave

19 (a) (b) Registrar
(Date rec'd by registrar)

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 1947 at 6 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1947 to Sept 16 1947, and that I last saw h alive on Sept 14 1947.

Immediate cause of death Myocarditis
Arterio Sclerosis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benj Kaplan M.D.
Address 2306 Eutaw Pl Date signed 9-16-47

G55192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G55192 Registered No. 108

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 14 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1633 Carey St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward F. Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	N N	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31, 1940.

8. AGE: Years	Months	Days	If less than one day
7	3	15	hr. min.

9. Birthplace Philadelphia, Pa (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Edward Smith.
13. Birthplace N. C.

MOTHER
14. Maiden Name Alma Lester.
15. Birthplace Philadelphia, Pa.

16 (a) Informant Alma Smith.
(b) Address 1633 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9- (month) (day) 1947 (year)
(c) Cemetery or crematory Philadelphia Pennsylvania
Location

18 (a) Funeral director Mrs Porter R Wallbrant
(b) Address 322 N. Schroeder St

19 (a) Date SEP 17 1947 registered (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/15 1947 at 8:20 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 9/14 1947, to 9/15 1947 and that I last saw him alive on 9/15 1947

Immediate cause of death Pneumonia — Duration

Due to — Duration 24 Hrs.

Due to — Duration years

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Preston Grant M.D.
Address 1514 Division Date signed 9/15/47

X

G55193 BALTIMORE CITY HEALTH DEPARTMENT G55193

CERTIFICATE OF DEATH 516

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 504 Harwood Av
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 504 Harwood Av
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME T. J. Luther Thomas

3 (b) If veteran, name war —

3 (c) Social Security Account No. 219-09-7088

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Katharine V.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22 1869

8. AGE: Years 78 | Months 2 | Days 23 | If less than one day hr. min.

9. Birthplace Rockey Mountain N. C.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name George W. Thomas
13. Birthplace N. C.

MOTHER
14. Maiden Name ? Fly
15. Birthplace N. C.

16 (a) Informant Katharine V. Thomas
(b) Address 504 Harwood Av

17 (a) Burial (b) Date thereof Sept. 18-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cod.
Location Belgid Rd.

18 (a) Funeral director John A. Holan
(b) Address 3814 E. Balto. St.

19 (a) 19 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15- 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946, to Sept. 15 1947, and that I last saw h[illegible] alive on Sept. 14 1947.

Immediate cause of death	Duration
Carcinoma, Prostate with metastasis.	14 mo.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. K. Kammer, Jr.
Address 701 Sheridan Ave. Date signed 9-17-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V S 150

Huntington Williams, M.D.

G55194

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G55194 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1505 John Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1505 John Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter Henry Hartle

3 (b) If veteran, name war: World War # 1
3 (c) Social Security Account No.:
4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Ester Hartle
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 5, 1885
8. AGE: Years 61 | Months 11 | Days 12 | If less than one day hr. min.
9. Birthplace Hagerstown, Maryland (Town, county, and state)
10. Usual Occupation Plummer
11. Industry or business City of Baltimore

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Emma Taylor
15. Birthplace Hagerstown, Maryland

16 (a) Informant Ester Hartle
(b) Address 1505 John Street

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/18/47 (month) (day) (year)
(c) Cemetery or crematory Dixon
Location Dixon, Missouri

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) SEP 18 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17, 1947, at 5:50 A M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1944 to Sept 17 1947, and that I last saw h in alive on Sept 17 1947.

Immediate cause of death: Cerebral hemorrhage — Duration: 10 hours
Due to: Arteriosclerosis — ?
Hypertension — ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Allen Deckert M.D.
Address 1114 St Paul St Date signed 9/17/47

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

Registered No. G55195

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green Streets
(c) Hospital or institution:
University Hospital 19.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1427 Fayette Street W.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gladys Flowers

3 (b) If veteran, name war: W
3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Common Law

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace Unknown
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Harry W. Flowers
(b) Address 1427 W. Fayette Street

17 (a) burial (b) Date thereof 9/18/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street.

19 (a) SEP 18 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 1947 at 8 00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/11 1947 to 9/14 1947
and that I last saw her alive on 9/14 1947

Immediate cause of death: Pulmonary infarct & cerebral arteriosclerosis — Duration: 15 mins
Due to auricular fibrillation
Due to mitral stenosis
Other Conditions Benign Cancer of left Endometrium
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Palmer M. D.
Address University Hospital Date signed 9/17/47

92B

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any wilful misstatement or omission of information should be carefully supplied. The

055196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 055196

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 E 23rd St Baltimore Md
(c) Hospital or institution:
Dr. Beck Diagnostic Clinic
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 214 E. Preston St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Henretta Etheridge

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
f.	w	

6 (b) Name of husband or wife Fred

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 13, 1885

8. AGE: Years	Months	Days	If less than one day
62	0	3	hr. min.

9. Birthplace England.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business —

FATHER
12. Name Henry Owen
13. Birthplace England

MOTHER
14. Maiden Name Sarah Halford
15. Birthplace England

16 (a) Informant Ella F. Yates
(b) Address 214 E. Preston Street

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 9/18/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Maryland

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) SEP 18 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 1947, at 3.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1945 to Sept 16 1947, and that I last saw her alive on Sept 15 1947

Immediate cause of death	Duration
Chronic Myocarditis	6 mos
Due to C Decompensation	
Due to	
Other Conditions Diabetes Mellitus Arteriosclerosis. (Include pregnancy within 3 months of death)	Indefinite

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Nathaniel M Beck M.D.
Address 100 E. 23rd St Date signed Sept 16

VS 150

93 D

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G55197

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 51 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 809 Brooks Lane, Balto 17 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel J. Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mrs. Leah Brown
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) March 9, 1896

8. AGE: Years	Months	Days	If less than one day
51	6	7	..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Wholesale Shoes
11. Industry or business

FATHER
12. Name: Mr. David Brown
13. Birthplace Russia

MOTHER
14. Maiden Name Lena Sulkin
15. Birthplace Russia

16 (a) Informant Mrs. Lena Brown
(b) Address 809 Brooks Lane, Balto 17, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 18/47 (month) (day) (year)
(c) Cemetery or crematory Arlington Park Cem.
Location Rogers Ave.

18 (a) Funeral director Sol Levinson & Bro.
(b) Address 1124-26 Reb. North Ave.

19 (a) (Registrar's signature) (b) Huntington Williams, M.D. Registrar

SEP 22 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17 1947, at 3:34 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 15 1947 to Sept. 17 1947, and that I last saw h[illegible] alive on Sept. 17 1947.

Immediate cause of death	Duration
Coronary Occlusion	2 days
Due to H.C.V.D. & Angina Pectoris	3-4 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. R. Smith, Jr. M. D.
Address Union Memorial Date signed 9/18/47

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55198

BALTIMORE CITY HEALTH DEPARTMENT

JU66 CERTIFICATE OF DEATH 194a

G55198 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1704 N. Chapel St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 N. Chapel St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Wubb

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Elizabeth M. Subb
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 5, 1866

8. AGE: Years	Months	Days	If less than one day
81	11	11	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Canner Retired
11. Industry or business

FATHER
12. Name Wm. Wubb
13. Birthplace England

MOTHER
14. Maiden Name — Engelhardt.
15. Birthplace Baltimore

16 (a) Informant Chas W. Wubb
(b) Address 1704 N. Chapel St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 19th (month) (day) (year)
(c) Cemetery or crematory Oak Hill Cem
Location City

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.

19 (a) SEP 18 1947 (Date rec'd by registrar) (b) Carrington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 1947 at 1 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-16- 1947, to ~~Sept 16 19~~; and that I last saw h~~im~~ alive on 19

Immediate cause of death	Duration
Coronary occlusion	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Conrad L. Richter
Address 1706 N. Wash. St. Date signed 9/17/47 M.D.

V S 150

Richter Howard J. Mullens, M.D.

C55199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

Registered No. C55199

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 293 N. Caroline St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nettie Lublin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: David Lublin

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 45 | Months — | Days — | If less than one day — hr. — min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Nathan
13. Birthplace ? Russia

MOTHER
14. Maiden Name Dina
15. Birthplace ? Russia

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-18-47 (month) (day) (year)
(c) Cemetery or crematory Cedar Israel
Location North Point & Germans Mill Rd

18 (a) Funeral director Jack Lewis Inc
(b) Address 2 E Eutaw Road

19 (Date rec'd by registrar) SEP 18 1947 Registrar Washington Millikan M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-17 1947 at 5:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-16-47 to 9-17 1947 and that I last saw h[illegible] alive on 9-17-1947.

Immediate cause of death: Subarachnoid Hemorrhage, Spontaneous
Due to: Cause unknown
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herman M. Millikoff M.D.
Address Johns Hopkins Hosp. Date signed 9/17/47

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

C55200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a ✓

Registered No. C55200

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3230 Burlith ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
5
(d) Street No. 3230 Burlith ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** (Mrs) Jannie Serpick

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband ~~or wife~~ Isaac Serpick

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Not known

8. AGE: Years 70 yrs | Months — | Days — | If less than one day ____ hr. — min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation At home

11. Industry or business —

FATHER
12. Name Bonuch Chertkof
13. Birthplace Russia

MOTHER
14. Maiden Name Frida Stana
15. Birthplace Russia

16 (a) Informant J. Serpick
(b) Address 3230 Burlith Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-18-47 (month) (day) (year)
(c) Cemetery or crematory Sharon Memorial Park
Location Windsor Mill Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 2400 Eutaw Pl

19 (Date rec'd by registrar) SEP 18 1947 Huntington Willis

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17 1947, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1947, to Sept 17 1947, and that I last saw h[illegible] alive on Sept 17 1947.

Immediate cause of death: Arteria Sclerosis — Cerebral hemorrhage — ? Duration 6 weeks

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Kadrw M. D.
Address 2306 Eutaw Pl Date signed 9-17-47

VS 150

X

G55201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G55201

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy 12-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1812 Eastland (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Jannie V. Norton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-24-77

8. AGE: Years 70 | Months 2 | Days 23 | If less than one day hr. min. 1877

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Teacher

11. Industry or business

FATHER 12. Name Patrick Norton
13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Brady
15. Birthplace Ireland

16 (a) Informant MRS. E. F. BOWIE
(b) Address 1819 GUILFORD AVE.

17 (a) -D- (Burial, cremation, or removal) (b) Date thereof 9-20-47 (month) (day) (year)

(c) Cemetery or crematory ST. MARY'S, GOUCHER'S
Location CITY

18 (a) Funeral director WIEDEFELD & SON
(b) Address GREENMOUNT AVE & 22ND ST.

19 (a) SEP 18 1947 (Date rec'd by registrar) (b) Huntington Hollins, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-17 1947, at 1:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-15 1947 to 9-17 1947, and that I last saw h[illegible] alive on 9-17 1947

Immediate cause of death Carcinomatosis — Duration 5 months

Due to Ca of Ovary — 3 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Hollins M. D.
Address Mercy Date signed 9-17-47

VS 150

G55202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G55202

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1129 Brewer st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-2
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1129 Brewer st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lora Mentzer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1885

8. AGE: Years	Months	Days	If less than one day
62	2	6	hr. min.

9. Birthplace Mercersburg, Pa.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Hezekiah Mateer
13. Birthplace Pa.

MOTHER
14. Maiden Name Sarah Stutz
15. Birthplace Pa.

16 (a) Informant Alexander Huntington
(b) Address 1129 Brewer st

17 (a) Burial (b) Date thereof 9-19-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore

18 (a) Funeral director Mullen & Jackson
(b) Address 916 Pennsa. Ave.

19 SEP 18 1947 (b) Huntington Williams, M.D. Registrar
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15 1947 at 12 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 12 1947 to Sept 15 1947, and that I last saw h[illegible] alive on Sept 15 1947.

Immediate cause of death Uremia — Duration 2 wks

Due to Hypertension Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.

Address Date signed 9/18/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

55203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G55203

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4712 Roland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-14
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ✓
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4712 Roland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosalie Williams Page

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Wm. C. Page
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 17 1864

8. AGE: Years 82 83 | Months 8 | Days 30 | If less than one day ..... hr. ..... min.

9. Birthplace Abbington Va.
(Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Maj Robert Alfred Williams (C.S.A.)
13. Birthplace Richmond, Va.

MOTHER
14. Maiden Name Elizabeth Marshall Colston
15. Birthplace Berkeley Va.

16 (a) Informant Douglas D. Lovell
(b) Address Harrison Md

17 (a) Burial (b) Date thereof Sept 18 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Thomas'
Location Garrison Forest Md

18 (a) Funeral director Henry N. Jenkins & Sons
(b) Address McCulloh & Orchard Sts

19 (a) 9 18 1947 (b) Thurston Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 1947, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1945 to 9/16 1947, and that I last saw her alive on 9/16 1947.

	Duration
Immediate cause of death Cerebral Hemorrhage	(3-4 days treated)
Arterio Sclerosis	"
Myocarditis	"
Due to Hypertension	"
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Goode M.D.
Address 1402 Park Ave Date signed 9/16/47

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C55204

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. C55204

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Provident 18-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20A
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 520 N. Freemont (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME John Kellum

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-12-5938

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 71 | Months | Days | If less than one day .....hr. .....min.

9. Birthplace.....
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business.....

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Etta Reith
(b) Address 520 N. Freemont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-18-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md.

18 (a) Funeral director Mrs. Frances H. Hemsley
(b) Address 578 W. Biddle St.

SEP 18 1947 (Registered by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/14/47 19..... at 10P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 9/15/47

X

55205

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G55205

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1071 Argyle Ave.
(c) Hospital or institution:
17-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1071 Argyle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MINNIE DURATE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Kenton Duratè
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 6, 1890

8. AGE: Years	Months	Days	If less than one day
49	1	10	hr. 18 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Garrett
13. Birthplace West River, Md.

MOTHER
14. Maiden Name Rachel Wilson
15. Birthplace Denton, Md.

16 (a) Informant Mr Kenton Duratè
(b) Address 1071 Argyle Ave.

17 (a) Burial (b) Date thereof 9-19-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Middle St.

SEP 18 1947
(Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16 1947, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-10 1947, to 9-16 1947
and that I last saw h alive on 9-16 1947

Immediate cause of death
Cerebral Hemorrhage — Duration 6 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.
Address Date signed 9-17-47

V S 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55206

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G55206

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1318 Bunday Ct.
(c) Hospital or institution:

25-6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25-7/12

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1318 Bunday Ct. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Maggie Johnson McNeely

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	M

6 (b) Name of husband or wife Eli

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15. 1902

8. AGE: Years	Months	Days	If less than one day
45	5	29	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name William Parmer
13. Birthplace Md

MOTHER 14. Maiden Name Sophia Thompson
15. Birthplace Md

16 (a) Informant Eli McNeely
(b) Address 1318 Bunday Ct

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) Sept 18-47

(c) Cemetery or crematory Mt Calvary Cem
Location A.A. Co Md

18 (a) Funeral director Albert E Williams
(b) Address 1515 McElderry St

19 (a) SEP 18 1947 (Date received by Registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13 1947, at 5 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-19 1945 to 9-13 1947, and that I last saw h.e.r alive on 9-5 1947.

Immediate cause of death cerebral hemorrhage — Duration scv. hrs

Due to hypertensive cardio-renal disease

Due to

Other Conditions Mummary carcinoma
(Include pregnancy within 3 months of death)

Date of operation 8-4-46

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Raynor Brown

Address 1500 E. Madison St Date signed 9/15/47

Raynor Brown 131a

VS 150

555207

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 46F

Registered No. 555207

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State D.C. (b) County
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 3901 Davis Place N.W. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Raymond Bowers

3 (b) If veteran, name war No

3 (c) Social Security Account No. 213-03-7851

4. Sex M.

5. Color or race W

6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Grace H. Bowers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18 1889

8. AGE: Years 58 Months 3 Days 30 If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Travel.

11. Industry or business XXXX

FATHER
12. Name Franklin P. Bowers.
13. Birthplace West Va.

MOTHER
14. Maiden Name Mary Colfy.
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Bowers.
(b) Address 3901 Davis Pl. Wash D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 19-1947 (month) (day) (year)
(c) Cemetery or crematory Rock Creek
Location Silver Hill Md.

18 (a) Funeral director Bowman & Sons
(b) Address 2224 N. Charles St.

19 SEP 18 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 Sept. 1947 at 1:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9 Sept 1947 to 17 Sept 1947. and that I last saw him alive on 17 Sept 1947.

Immediate cause of death Cachexia — Duration

Due to Carcinomatosis

Due to Carcinoma of gall bladder.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation July 11 1947.

Major findings of operation: Carcinoma gall bladder & metastases

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. W. Johnson III M. D.
Address Union Mem. Hosp Date signed 17 Sept 47

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

055208 424 90 D

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 50 ✓

Registered No. 055208

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Ferndale, Md.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charlotte Meacham

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Married

6 (b) Name of husband or wife Edward
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-18-16

8. AGE: Years	Months	Days	If less than one day
30	9	26	hr. min.

9. Birthplace Penn.
(Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name John Richardson.
13. Birthplace W. Va.

MOTHER
14. Maiden Name
15. Birthplace ?

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Sept 18 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto Md
18 (a) Funeral director Isaiah L Brown Jr
(b) Address 1818 Montgomery St
SEP 18 1947 Huntington Williams
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14 1947 at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7 1947 to Sept 14 1947 and that I last saw he[r] alive on Sept 14 1947.

Immediate cause of death Carcinoma involving liver, kidneys, spine, lungs, ovary, breast — Duration 3 months
Due to Primary site may have been breast or kidney
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Carcinoma (on slide)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature David Grob M. D.
Address J H H Date signed 15 Sept 47

X

G55209

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G55209 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Church & Longfellow
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Bal
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2407 Roslyn Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME M. Joseph Muth (M. JOSEPH MUTH)

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-6610

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Mrs Joseph Muth Genevieve 6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) 9-2-97

8. AGE: Years	Months	Days	If less than one day
50	—	14	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Grain Mill Bus

11. Industry or business Business

FATHER 12. Name John S. MUTH
13. Birthplace Md

MOTHER 14. Maiden Name Mary Rickert
15. Birthplace Md

16 (a) Informant Mrs. Geneyieve Keating Muth
(b) Address 2407 Roslyn ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/19/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. D. Grogan Son Inc.
(b) Address 18 N. Mt. Royal Ave

19 SEP 18 1947 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-16 1947, at 1:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-15 1947 to 9-16 1947, and that I last saw h alive on 9-14 1947.

Immediate cause of death Coronary Thrombosis

Duration 2 Days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm Bart M. D.
Address Mercy Date signed 9-16-47

55210

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

Registered No. G55210

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 51st St.
(c) Hospital or institution:
US Marine Hospital 19-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 19 N. Gilmor St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME William Charles Scribner

3 (b) If veteran, name war	3 (c) Social Security Account No.
WW I	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	col	Married

6 (b) Name of husband or wife Agnes Brown Ball
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Aug. 11, 1894

8. AGE: Years	Months	Days	If less than one day
53	1	4	____ hr. ____ min.

9. Birthplace King George Co. Va.
(Town, county, and state)
10. Usual Occupation Cook
11. Industry or business

FATHER
12. Name John Schribner
13. Birthplace Va.

MOTHER
14. Maiden Name Marian ?
15 Birthplace Va.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (b) Date thereof Sept. 19, 1947
(Burial, cremation or removal) (month) (day) (year)
(c) Cemetery or crematory National
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Stricker St Huntington Williams, Md.

19 SEP 18 1947 [illegible]
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15 1947, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 11 1947 to Sept. 15 1947, and that I last saw him alive on Sept. 15 1947.

Immediate cause of death	Duration
(1) Fibrosis of lungs, chronic, involving both upper lobes	5 yrs
(2) Cardiac hypertrophy with congestive failure	6 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon 9/16/47
Address Clinical Director Date signed

V S 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

126

Registered No. G55211

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5355 Plumwood ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patsy Howard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | Color or race Colored | 6 (a) Single, married, widowed, or divorced W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) 12-25-89

8. AGE: Years 57 58 | Months — 8 | Days 22 | If less than one day — hr. — min.

9. Birthplace Ala.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Steve Friel
13. Birthplace Ohio

MOTHER 14. Maiden Name Rosetta Dupaire
15. Birthplace Ala.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Sept. 20, 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Alliance - Ohio
Location

18 (a) Funeral director Clegg & Wilson
(b) Address 1000 Bentley Ave

19 (a) SEP 18 1947 (b) Huntington Williamsport, Md.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION 1947

20. DATE OF DEATH 9-16-47, at 845 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-11-47 to 9-16 1947, and that I last saw her alive on 9-16-47.

	Duration
Immediate cause of death: Coronary occlusion	about 2 hrs
Due to: Arteriosclerosis	? years
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation 9-16-47

Major findings of operation: Cholecystitis, chronic; cholelithiasis

If autopsy: Atherosclerosis, myocardial infarction

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rowena Spencer M. D.
Address Johns Hopkins Hospital Date signed 9-17-47

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

655213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

176

Registered No. 655213

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto. City Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Kent
(c) City or town Rock Hall
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nelson Leroy Colliyer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Madge Edwards

6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) 1915

8. AGE: Years 32 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Rock Hall, Kent Co., Md
(Town, county, and state)

10. Usual Occupation American Dredge Co.

11. Industry or business

FATHER
12. Name Charles Milton Colliyer
13. Birthplace Kent Co., Md

MOTHER
14. Maiden Name Ida Grant
15. Birthplace Kent Co., Md.

16 (a) Informant Charles Milton Colliyer
(b) Address Rock Hall, Kent Co. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-21-47 (month) (day) (year)
(c) Cemetery or crematory Wesley M. Chapel
Location Rock Hall, Md

18 (a) Funeral director Marvin V. Williams
(b) Address Chestertown, Md.

19 (a) SEP 18 1947 (Date rec'd by registrar) (b) Marvin V. Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18, 1947, at 8:50 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Rupture of heart

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9/18/47 7P M.
(b) Where did injury occur? Near Bay Shore, Balto. Co.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Struck in chest with derrick chain

23. Signature [signature] M.D.
Medical Examiner.
Date signed 9/18/47

Correct age if apparently inaccurate. Physician: please write the causes of death clearly and legibly.

G55213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G55213 Registered No. 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2226 Wilkens Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2226 Wilkens Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edna Virginia Burrows

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-7692

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Divorced

6 (b) Name of husband or wife John Burrows
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1889

8. AGE: Years	Months	Days	If less than one day
58	4	-	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Seamstress
11. Industry or business

FATHER
12. Name Thomas H. Paul
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Katherine Wunder
15. Birthplace Baltimore, Md.

16 (a) Informant Harry J. Paul
(b) Address 2917 N. Calvert St.

17 (a) Burial (b) Date thereof Sept. 18, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Frederick A. Cole
(b) Address 1200 W. Lombard St.

19 (a) SEP 18 1947 (b) Huntington Williams M.D.
(Date received by registrar) (Signature of registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15, 1947, at 8:?? M

21. I certify that death occurred on the date above stated; that I attended deceased from 4 4 1947 to 9 15 1947, and that I last saw h[illegible] alive on 9 6 1947

Immediate cause of death: Myocardial Infarction. — Duration:
Due to: Arteriosclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jos. Sklover, M. D.
Address 7122 Karlyn Rd Date signed 9-17-47

Jos. Sklover

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

55214

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G55214

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 530 N. Fulton Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT PALMER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Bladys Palmer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1910

8. AGE: Years 37 | Months | Days | If less than one day hr. min.

9. Birthplace Petersburg, Va.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER
12. Name Joseph Palmer
13. Birthplace Va.

MOTHER
14. Maiden Name Pearl Bonner
15. Birthplace Va.

16 (a) Informant Pearl Palmer
(b) Address 1415 E. Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/21/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. County Md.

18 (a) Funeral director Joseph L. Locke
(b) Address 1304 N. Central Ave

SEP 19 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 1st

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18, 1947, at 12.30 M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions Syphilitic Aortitis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Nelson M.D.
Medical Examiner.
Date signed 9-18-47

94a

Correct age is especially important. If unknown, please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

355215

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G55215 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3700 Gelston Drive
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1130 Scott St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Kalter

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 5, 1877

8. AGE: Years	Months	Days	If less than one day
70	5	17	hr. min.

9. Birthplace Baltimore Md
(Town, county, or state)
10. Usual Occupation Clerk - Retired
11. Industry or business Emerson Drug Co

FATHER
12. Name Henry Kalter
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Hansen
15. Birthplace Norway

16 (a) Informant Charles Kalter
(b) Address 3700 Gelston Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 20 1947 (month) (day) (year)
(c) Cemetery or crematory Western
Location City

18 (a) Funeral director Mr. Mrs. John W. Teufel & Son
(b) Address 5311 Edmondson Ave

19 (a) Sept 19 1947 (Date received by local registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18 1947, at 5:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from February 1946 to Sept 18 1947, and that I last saw him alive on Sept 17 1947.

Immediate cause of death	Duration
(a) Hypostatic Pneumonia	4 days
Due to (b) Arteriosclerotic Dementia	several years
Due to (c) Chronic Myocardial Deficiency & Degenerative	
Other Conditions Hypertension, Glaucoma, Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature W. Michel M. D.
Address 2901 Edmondson Ave. Date signed Sept 19 47

55216

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. C55216

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2648 Flora Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2648 Flora Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT E. JENIFER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Mamie Jenifer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1892

8. AGE: Years	Months	Days	If less than one day
55 54	5 4	17	hr. min.

9. Birthplace St. Mary Co., Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Frank Jenifer
13. Birthplace Md.

MOTHER
14. Maiden Name Lizzie Jones
15. Birthplace Md.

16 (a) Informant Mrs. Mamie Jenifer
(b) Address 2648 Flora St.

17 (a) Burial (b) Date thereof 9-22-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory National Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St

19 (a) SEP 19 1947 (b) Huntington Williams
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH Sept. 18, 1947, at 7:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12-47 to Sept 18 1947 and that I last saw h[illegible] alive on Sept 16 1947

Immediate cause of death

	Duration
(a) Pulm Tuberculosis	9
Due to	
Due to	
Other Conditions E. T. Laryngitis	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury

23. Signature S. B. Hughes M. D.
Address 1443 Druid Hill Ave Date Sept 18-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

55217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

G55217
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 63 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore-10 (If outside city or town limits, write RURAL and give town)
(d) Street No. 209 Edgevale Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME HORACE TAYLOR SMITH

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of ~~husband or~~ wife Mabel Wolf Smith

6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) JUNE-30-1884

8. AGE: Years 63 | Months 2 | Days 18 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Lawyer

11. Industry or business

FATHER 12. Name Horace Lawrence Smith

13. Birthplace Mississippi

MOTHER 14. Maiden Name Elizabeth J. Nimmo

15. Birthplace Virginia

16 (a) Informant Mabel Wolf Smith (wife)

(b) Address 209 Edgevale Rd Balto Md.

17 (a) Burial (b) Date thereof 9-19-47 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville-Md.

18 (a) Funeral director STEWART & MOWEN COMPANY

(b) Address [illegible]

SEP 19 1947 (Date rec'd by registrar)

Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17 1947 at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7 1947 to Sept 17 1947, and that I last saw him alive on Sept 17 1947.

Immediate cause of death	Duration
Cardiac collapse	3 hours
Due to	
Due to	
Other Conditions Adeno Carcinoma rectum	6 months

(Include pregnancy within 3 months of death)

Date of operation Sept. 11, 1947

Major findings of operation: Carcinoma of rectum

of autopsy: negative

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Glenn P. Brove M.D.

Address Union Memorial Hosp. Date signed 9-17-47

X

55218

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G55218

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important. Undertakers: please write correct spelling of names.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2009 Elsinor Ave
(c) Hospital or institution
15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2009 Elsinor Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Siegel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bessie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 68 | Months | Days | If less than one day ...hr. ...min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Furniture Store

11. Industry or business

FATHER
12. Name Getzel
13. Birthplace Russia

MOTHER
14. Maiden Name Riva
15. Birthplace Russia

16 (a) Informant Bessie Siegel
(b) Address 2009 Elsinor Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-19-47 (month) (day) (year)
(c) Cemetery or crematory
Location New Shrine Herring Run

18 (a) Funeral director Jas. C. Lewis Inc
(b) Address 2100 Eutaw Place

19 SEP 19 1947 (Date rec'd by registrar) (b) Burlington Williamsport Md

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-18-1947, at 4:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 11 1947 to 9/18 1947 and that I last saw h[illegible] alive on 9/17/ 1947.

Immediate cause of death: Coronary Thrombosis — Duration: 1 week

Due to

Due to

Other Conditions: Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas Cooper M. D.
Address 2201 Eutaw Place Date signed 9/19/47

G55219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

G55219
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd St.
(c) Hospital or institution: The Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 Da.
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1619 North Smallwood St., City
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Russia

3 (a) FULL NAME Mrs. Mary Frank

3 (b) If veteran, name war —

3 (c) Social Security Account No. — —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband ~~deceased~~ M. Harry Frank
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
63 62	—	—	..... hr. ..... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business —

FATHER
12. Name Samfel Thiberg
13. Birthplace Russia

MOTHER
14. Maiden Name Dorey ?
15. Birthplace Russia

16 (a) Informant Mr. Samuel Frank (son)
(b) Address 1619 North Smallwood St. City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-19-47 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Herring Run

18 (a) Funeral director Jack Lewis Inc
(b) Address 2600 Eutaw Place

19 SEP 19 1947 (Date rec'd by Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17 1947 at 9.26 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1 1947 to Sept 17 1947, and that I last saw her alive on Sept. 17 1947.

Immediate cause of death Carcinoma of Head of Pancreas

Duration

Due to Common Bile Duct

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9-3-47

Major findings of operation: Ca of Head of Pancreas

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James M. C. Fenney M. D.
Address Union Memorial Hosp Date signed 9-17-47

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G55220

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2630 Loyola Southway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Bala
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2630 Loyola Southway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BESSIE LEVY

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex FEMALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced WIDOW

6 (b) Name of husband or wife HANUS

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1840

8. AGE: Years 97 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation HOUSE WORK

11. Industry or business

FATHER
12. Name MORRIS
13. Birthplace RUSSIA

MOTHER
14. Maiden Name MARY
15. Birthplace RUSSIA

16 (a) Informant LILLIAN KRONGARD

(b) Address 5126 Woodbourne Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-19-47 (month) (day) (year)

(c) Cemetery or crematory HERRING RUN

Location Phil Rd + Bowleys Lane

18 (a) Funeral director JACK LEWIS INC

(b) Address 2100 EUTAW PL.

19 (a) SEP 19 1947 (Date received by Registrar) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-18-47 19__, at 12:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19 47 to Sept 19 47 and that I last saw h alive on 17 Sept 19 47

Immediate cause of death	Duration
Cerebral Embolism	10 min
Due to Coronary thrombosis	5 days
Due to Hypertensive Cardiovascular Disease	10 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph B. Gross M.D.

Address 1001 Eutaw Place Date signed Sept 19 1947

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

55221

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C55221

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3010 W Rogers Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3010 W Rogers Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sarah Steinberg

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Jacob

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years 57 | Months | Days | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER 12. Name Louis

13. Birthplace Russia

MOTHER 14. Maiden Name Leah

15. Birthplace Russia

16 (a) Informant Jacob Steinberg

(b) Address 3010 W Rogers Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-19-47 (month) (day) (year)

(c) Cemetery or crematory United Hebrew

Location Washington Boulevard

18 (a) Funeral director Jack Lewis Inc

(b) Address 2100 Eutaw Place

SEP 19 1947 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-18-1947 at 6P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 18 1947 to Sept. 18 1947 and that I last saw h[er] alive on Sept. 18 1947

Immediate cause of death: Cerebral Hemorrhage — Duration 3½ hours

Due to: Hypertension Cerebro Vascular Disease — Duration ?

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip F. Larsen

Address 2401 W. Nath Ave Date signed 9/19/47 M. D.

V S 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

55222 XE-113636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓107

G55222 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 2yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 600 N. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Sullivan

3 (b) If veteran, name war

3 (c) Social Security Account No. 0300-762-84

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Separated

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28-1894

8. AGE: Years	Months	Days	If less than one day
53	7		hr. min.

9. Birthplace Mass.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John E. Sullivan
13. Birthplace Maine

MOTHER
14. Maiden Name Mary Hayes
15. Birthplace Mass.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/19/47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Gerrmyn Hill Rd.

18 (a) Funeral director John J. Fahey & Sons
(b) Address 1305 Light St.

19 (a) SEP 9 1947 (Date rec'd by registrar) (b) Huntington Williams Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6 1947, at 11.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-6- 1947 to 9-6- 1947, and that I last saw h. im alive on 9-6- 1947.

Immediate cause of death	Duration
Bronchopneumonia	
Due to Bronchiectasis	
Due to (a)	
Other Conditions ? pulmonary tbc.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Haden Jr. M. D.
Address Balto City Hosp Date signed 9/8/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G55223 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3711 Edmondson Rd
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3711 Edmondson Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie Lewis

3 (b) If veteran, name war: NW
3 (c) Social Security Account No.: NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife: Kennie B. Lewis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14th 1883

8. AGE: Years	Months	Days	If less than one day
64	2	4	hr. min.

9. Birthplace Dorchester Co. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name William Dukes
13. Birthplace Dorchester Co. Md.

MOTHER
14. Maiden Name Mary Baxbridge
15. Birthplace Dorchester Co. Md.

16 (a) Informant Kennie B. Lewis
(b) Address 3711 Edmondson Rd

17 (a) Burial (b) Date thereof 9/22/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 SEP 19 1947 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18th 1947, at 6:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1st 1947, to Sept 18 1947, and that I last saw h alive on 9/18 of 19.

Immediate cause of death	Duration
Carcinoma L. Breast	1 yr
Due to	
Due to	
Other Conditions: Metastatic Cancer R Pleura & Pericardium. (Include pregnancy within 3 months of death)	4 mos

Date of operation
Major findings of operation: Carcinoma L. Breast
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. T. Thompson M. D.
Address 1710 E. 23rd St. Date signed 9/19/47

PRINT NAME, ADDRESS, AND OCCUPATION IN PENCIL. Every item of information should be carefully supplied. Use ink; write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

55224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

G55224 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 501 Cidercroft Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 501 Cidercroft Rd (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emanuel B Chapman

3 (b) If veteran, name war WW I | 3 (c) Social Security Account No. None

4 Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 26 1878

8. AGE: Years 69 | Months 0 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Florist Retired

11. Industry or business

FATHER 12. Name Daniel H Chapman

13. Birthplace Md

MOTHER 14. Maiden Name Mary C Druff

15. Birthplace Md

16 (a) Informant Mary C Chapman

(b) Address 501 Cidercroft Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/19/47 (month) (day) (year)

(c) Cemetery or crematory Ashland Cemetery

Location Baltimore Co Md

18 (a) Funeral director Wilson & Son

(b) Address 1217 Park Ave

19 SEP 19 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17 1947, at 9:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1947 to Sept 17 1947, and that I last saw h. alive on Sept 10 1947.

Immediate cause of death Cerebral Hemorrhage (2 hr)

Due to Hypertension

Due to

Other Conditions Last stroke 3 years ago

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Karl Traugott M. D.

Address 1623 E. N. Avenue Date signed 9/19/47

X

Every item of information should be given correctly as directly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

655225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

655225 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Don.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 606 East Baltimore St. (If rural give location)
(e) Citizen of foreign country?..... (Yes or No) If yes, name country.....

3 (a) FULL NAME Frank Braun

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 11 1890

8. AGE: Years	Months	Days	If less than one day
57	1	6	....hr. ....min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Cashier
11. Industry or business Pal's Restaurant

FATHER
12. Name Martin Braun
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Mary Rosemann
15. Birthplace Pennsylvania

16 (a) Informant Mrs. Nettie Howard
(b) Address 2239 N. Franklin St. Phila.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-20-47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd.

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St

SEP 19 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17, 1947, at 11 45 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary disease, generalized arteriosclerosis and

Due to chronic myocarditis

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Howard A. Mallers M.D. Medical Examiner.
Date signed 9/17/47

Write ages in capitals. Physicians: please write the causes of death clearly and legibly.

655226

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83c

Registered No. 655226

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 2476 Shirley Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days): 56 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 2704 Hilldale Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: JENNIE SATTEL

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Jennie

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 20, 1874

8. AGE: Years: 73 | Months: 2 | Days: 28 | If less than one day: hr. min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual Occupation: House Wife

11. Industry or business:

MOTHER / FATHER

12. Name: Israel Gradman

13. Birthplace: Russia

14. Maiden Name: Fruma Yaffe

15. Birthplace: Russia

16 (a) Informant: Reuben Sattel

(b) Address: 2704 Hilldale Ave

17 (a) Burial (b) Date thereof: Sept 19, 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory: Workmen Circle Cemetery

Location: German Hill Road

18 (a) Funeral director: Sol Levinson & Bros

(b) Address: 1124-1126 W North Ave

19. SEP 19 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

5.20

20. DATE OF DEATH: September 18 1947, at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 25 1945, to Sept 18 1947, and that I last saw her alive on Sept 18 1947.

Immediate cause of death: Arteriosclerosis & Encephalomalacia — Duration: 2 yrs

Due to:

Due to:

Other Conditions: None

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Louis Blum, M.D.

Address: 230 Eutaw Pl Date signed: 9/18/47 M. D.

VS 150

X

G55227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G55227 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1527 W. Monroe Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1832 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK SNOW

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Cornelia W. Snow
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 17, 1861

8. AGE: Years	Months	Days	If less than one day
86	7	0	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Salesman, retired
11. Industry or business

FATHER
12. Name Charles H. Snow
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Ellen Inloes
15. Birthplace Baltimore, Maryland

16 (a) Informant Miss Ellen Snow - daughter
(b) Address 1832 N. Broadway

17 (a) Burial (b) Date thereof 9/19/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 SEP 19 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17, 1947, at 12.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug-19-1947 to Sept 17 1947 and that I last saw him alive on Sept 17 - 1947

Immediate cause of death	Duration
Edema Lungs	2 days
Due to Chronic Myocarditis	3 yrs
Other Conditions Arterio-Sclerosis	10 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E. North Ave Date signed 9/18/47

55228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No. 655228

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1814 Druid Hill Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1814 Druid Hill Ave. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Ellen Stokes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Horace B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14, 1884

8. AGE: Years 62 | Months 10 | Days 4 | If less than one day hr. min.

9. Birthplace Heathsville, Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Peasley
13. Birthplace Virginia

MOTHER
14. Maiden Name Lucy Coleman
15. Birthplace Virginia

16 (a) Informant Horace Edward Stokes
(b) Address 1814 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Jno. George H. Holland
(b) Address 1821 Druid Hill Ave

19 (a) SEP 9 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS-150 [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16, 1947 at 4:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-9- 1947 to 9-16 1947 and that I last saw her alive on 9-16- 1947.

Immediate cause of death	Duration
Coronary thrombosis	
Due to Arteriosclerosis	11-20 yrs
Due to Hypertension & Dilatation of Heart	5 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jno. H. Williams M. D.
Address 6723 Druid Hill Ave Date signed 9-17-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

X 9-17-47

53229

JL - 113441

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1362

G55229 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 25 S. Stricker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Scheerer, or James Sheerer, James Scherer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Div.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 11, 1898

8. AGE: Years 49 | Months 8 | Days 6 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William C. Scheerer
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Negle
15. Birthplace Ireland

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/20/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Druid Hill Ave

18 (a) Funeral director J. J. Lafayette Jones
(b) Address 1379 Light St.

SEP 19 1947 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17 1947 at 9AM M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 30 1947 to Sept. 17 1947, and that I last saw h... alive on Sept. 17 1947

Immediate cause of death	Duration
Anoxemia	25 da
Due to Pulmonary emphysema	2 yr
Due to Tuberculosis of larynx, fibroid, far advanced	16 yr
Other Conditions Rt. ht. heart hypertrophy, Chronic passive congestion of	

(Include pregnancy within 3 months of death)

Date of operation 10-12-45

Major findings of operation: Tuberculous enteritis

of autopsy: viscera

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph J. Bowen Jr. M. D.
Address Balt. City Hosp. Date signed 9-17-47

X

If any of the above items are unknown, please write the causes of death clearly and legibly. Physicians: please write correct age is especially important. Every item of information should be carefully supplied. The

G55230 (7) SB 34660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 144a

Registered No. G55230

Every item of information should be carefully supplied. Please write the causes of death clearly and legibly. Physicians: please write in ink, and sign your name. Especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 dys.
(e) Length of stay in Baltimore (yrs., mos., or days) 29 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2009 E Oliver St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Foxen, Beulah (May) Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/13/18

8. AGE: Years	Months	Days	If less than one day
29	7	4	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Laundress
11. Industry or business Fulton Laundry

FATHER
12. Name Wm H. Foxen
13. Birthplace Md

MOTHER
14. Maiden Name Ethel L. Jackson
15. Birthplace Md

16 (a) Informant George E Foxen
(b) Address Stonybrook Rd. Baltimore Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 20 1947 (month) (day) (year)
(c) Cemetery or crematory Morlands
Location Taylor Ave

18 (a) Funeral director Leo G. Leach
(b) Address 1201-03 N. Patterson Park Ave

19 (a) SEP 9 1947 (Date received by local registrar) (b) Huntington Williamsville Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/17 1947 at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/16 1947 to 9/17 1947 and that I last saw her alive on 9/17 1947

Immediate cause of death	Duration
Cardio-Respiratory failure	12 hr.
Due to Pulmonary Edema	12 hr.
Due to Eclampsia	1+ day
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Post Mortem Section
Major findings of operation: Stillborn 6¼ lb Fetus
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James S. Shortle M. D.
Address St. Josephs Hospital Date signed 9/17/47

655231

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

655231 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 715 S. Linwood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 715 S. Linwood Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AUGUSTA ZYBLEWSKI

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Frank
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/22/1859

8. AGE: Years	Months	Days	If less than one day
87	8	26	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Augusta Carlson
(b) Address 715 S. Linwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/20/47 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M.F. Sadowski & Sons
(b) Address 1805 Eastern Avenue

SEP 19 1947 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-17 1947, at 8:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-16 1947 to 9-16 1947 and that I last saw h[illegible] alive on 9-16 1947.

Immediate cause of death Chronic Myocarditis — Duration

Due to Cardiac decompensation (Senile)

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 2901 E. Monument St Date signed 9-19-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55232

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G55232 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Temple Harbor Apts.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Temple Harbor Apts. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Blanche A. Weinberg

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Henry Weinberg
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/31/1865

8. AGE: Years	Months	Days	If less than one day hr.	min.
82	5	17		

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Samuel Salomon
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Bertha
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Samuel Weinberg
(b) Address Temple Harbor Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/19/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Baltimore, Md.

18 (a) Funeral director Harris Levine & Sons
(b) Address 1902 E. Fayette St.

SEP 19 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17 1947 at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1947 to Sept. 17 1947; and that I last saw h[illegible] alive on Sept. 17 1947.

Immediate cause of death: Coronary Occlusion
Antecedent Cerebral Hemorrhage
Arteriosclerotic Heart Disease
Due to
Other Conditions: Coronary Artery Disease
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

Duration: Chronic 6 mos. / 10 yrs. / 12 yrs.

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Lon Brockett
Address Cherrydale Apts. Date Signed Sept 17 1947

VS 150

Write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

55233

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

Registered No. G55233

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 332 S. Collington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 332 S. Collington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank J. Wisniecki

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-03-8111

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Catherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 53 | Months | Days | If less than one day: hr. min.

9. Birthplace: Balto, Md. (Town, county, and state)

10. Usual Occupation: Foreman

11. Industry or business: Pioner Service Co

FATHER
12. Name: Stanley Wisniecki
13. Birthplace: Poland

MOTHER
14. Maiden Name: Mary Dlymska
15. Birthplace: Poland

16 (a) Informant: Catherine Wisniecki
(b) Address: 332 S. Collington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 22-47 (month) (day) (year)
(c) Cemetery or crematory: Holy Rosary
Location: German Hill Rd

18 (a) Funeral director: Wm. J. Fialkowski
(b) Address: 2007 Eastern Ave

19 SEP 19 1947 (Date rec'd by registrar) (b) Huntingtown Williamsport Md

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17 1947 at 9:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 1946 to 9/17 1947 and that I last saw h- alive on 9/17 1947.

	Duration
Immediate cause of death: Cerebral Hemorrhage	12 [illegible]
Due to: General arteriosclerosis	?
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature H. J. Jenkins M. D.

Address 100 N. Mulberry Date signed 9/17/47

55234

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131a

G55234 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2005 E. Hoffman St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2005 E. Hoffman St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie L. Reed

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1863

8. AGE: Years	Months	Days	If less than one day
84	2	1	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Lewis Kisil

13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Mary L. Kisch

15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Jennie Cullison

(b) Address 2005 E. Hoffman St.

17 (a) Burial (b) Date thereof 9/22/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore County

Location North Point Blvd & Eastern ave

18 (a) Funeral director Howard M. Bright

(b) Address 4914 Belair Road.

19 (a) SEP 19 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1947, at 6:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from December 1939, to Sept 19 1947, and that I last saw her alive on Sept 18 1947.

Immediate cause of death	Duration
Bronchopneumonia	3 days
Due to Hypertensive cardio-vascular renal disease	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Helen J. Longsworth M. D.

Address 1445 N Gay St Date signed 9/19/47

Please write the causes of death clearly and legibly. Physicians: please write in the information asked for carefully supplied. The correct age is especially important.

G55235

435-140

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

95c

Registered No. G55235

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1818 Aliceanna, St. (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Walter Delinski. WLADYSLAW DELINSKI

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-9775

MEDICAL CERTIFICATION 05

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mary Delinski
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 10-?-13

8. AGE: Years	Months	Days	If less than one day
34	11		....hr. ....min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Laundry man
11. Industry or business

FATHER
12. Name Peter Delinski
13. Birthplace Md.

MOTHER
14. Maiden Name Helen ?
15. Birthplace Md.

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 9-22-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~.....~~ Holy Rosary
Location Baltimore, Md.

18 (a) Funeral director George A Weber
(b) Address 705 S. Gay st Huntington Williams, Md

SEP 19 1947
(Date rec'd by registrar) Registrar

20. DATE OF DEATH Sept-18- 1947 at 12 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-12- 1947 to 9-18- 1947 and that I last saw h~~e~~r alive on 9-18- 1947.

Immediate cause of death	Duration
malignant hypertension	6 wks
Due to acute glomerulonephritis	
Due to	
Other Conditions hypertensive encephalopathy	

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings ~~of operation~~: enlarged heart, hemorrhages kidneys
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature J H Lesson M. D.
Address Johns Hopkins Hospital Date signed 18 Sept '47

VS 150

122

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

655236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 109B

Registered No. 655236

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1530 Covington St
(If rural give location)
(e) Citizen of foreign country? / (Yes or No)
If yes, name country.....

3 (a) FULL NAME Naomi Kelly

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife William P. Kelly
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 24. 1909

8. AGE: Years 37 | Months 9 | Days 24 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Little
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Edith Knapper
15. Birthplace Baltimore Md

16 (a) Informant William P. Kelly
(b) Address 1530 Covington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-20-1947 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore

18 (a) Funeral director Flynn & Fleming
(b) Address 1420 Light St

1947 SEP 19 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION 25

20. DATE OF DEATH September 18 1947 at 5 a. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute congestive cardiac vessels, edema and congestion of lungs

Due to.....

Other Conditions History of epilepsy
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Howard J. Masters M.D.
Medical Examiner.
Date signed 9-18-47

X

555237

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 555237

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 583 N. Gay Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAX GREENSPUN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Dora

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
47			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation merchant

11. Industry or business

FATHER
12. Name Alexander
13. Birthplace Russia

MOTHER
14. Maiden Name Mollie
15. Birthplace Russia

16 (a) Informant Dora Greenspun
(b) Address 583 N Gay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-19-47 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Herring Run

18 (a) Funeral director Jack Lewis Inc
(b) Address 2160 Eastern Place

19 SEP 19 1947 (Date rec'd by registrar) (b) Courtesy for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/18/47 19 , at 10:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis, M.D. Medical Examiner.
Date signed 9/19/47

G55238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

VS

G55238 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1903 Lemmon St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1903 Lemmon St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edna V. Ellender

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~ Widowed

6 (b) Name of husband ~~or wife~~ George Ellender

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 29th 1889

8. AGE: Years 57 | Months 8 | Days 19 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER 12. Name Wm Dreb[illegible]

13. Birthplace Balto Md.

MOTHER 14. Maiden Name Mary Dunn

15. Birthplace Balto. Md.

16 (a) Informant Mrs. Myrtle Hall

(b) Address 032 Lehew Way - Arundel Gardens

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof Sept 20th 1947 (month) (day) (year)

(c) ~~Cemetery or crematory~~ Woodlawn

Location Woodlawn Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St Paul St.

19 (a) SEP 19 1947 (Date rec'd by Registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18th 1947 at 9 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 4 1947 to 9/18 1947 and that I last saw h[illegible] alive on 9/18 1947.

Immediate cause of death	Duration
Coronary occlusion	3 mos
Due to Generalized arteriosclerosis	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M. D.

Address 1030 Wilkens Ave Date signed 9/19/47

VS 150

FOR WHITE PERSONS, WITH UNDERLINING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55239

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G55239 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4001 Groveland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4001 Groveland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Terrence Maguire

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Eva B. Maguire
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 1 1880

8. AGE: Years	Months	Days	If less than one day
67	1	18	hr. min.

9. Birthplace Wheatville N.Y. (Town, county, and state)
10. Usual Occupation Mec. Engineer
11. Industry or business Koppers Corp.

FATHER
12. Name Daniel A. Maguire
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Clancey
15. Birthplace Scotland

16 (a) Informant Robert B. Maguire
(b) Address 3901 Dorchester Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 22 1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Harry Kenwood
(b) Address 4204 Ridgewood Ave

19 SEP 19 1947 (Date rec'd by registrar) (b) Thornton for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19 1947, at 6.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1943, to Sept 1947, and that I last saw h alive on Sept. 18 1947.

Immediate cause of death	Duration
Coronary thrombosis	Sudden
Due to arterio sclerosis	?
Due to Hypertension	4 yrs
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Wetherbee Fort
Address 20 S. Bouton St. Date signed 9/19/47 M. D.

Wetherbee Fort

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55240 166699

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH · 13B

Registered No. G55240

Every item of information should be carefully supplied. Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 403 Freeland St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Naomi Rooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-12-18

8. AGE: Years 28 | Months 6 | Days 5 | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Walker Stratton
13. Birthplace Va.

MOTHER
14. Maiden Name Emma Bevely
15. Birthplace Va

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 21 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A A County Md

18 (a) Funeral director Mrs. Robt A. Elliott Dept
(b) Address 1129 N. Caroline St

19 SEP 19 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17 1947, at 7 30 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 8 1947 to Sept 17 1947 and that I last saw h[illegible] alive on Sept 17 19 47

Immediate cause of death	Duration
Tuberculosis.	
~~Lymphogranuloma Venereum.~~	
Due to Tuberculosis miliary.	
Due to Lymphogranuloma Venereum.	
Other Conditions ~~Tuberculosis miliary~~	

(Include pregnancy within 3 months of death)
Date of operation None.
Major findings of operation: None.
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert P. O'Donnell, M.D.
Address Johns Hopkins Hospital Date signed 9-16-47 M. D.

X

G55241

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

6007 V 94a

Registered No. G55241

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2202 E. Hoffman St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mr. Charles J. Gorman (Gorman)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mrs. Mary Gorman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/3/82 81

8. AGE: Years	Months	Days	If less than one day
66 65	5	15	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Receiving & Shipping Clerk
11. Industry or business B. V. D. Corp.

FATHER
12. Name John J. Gorman
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary Jane Lally
15. Birthplace Maryland

16 (a) Informant Mrs. Mary O. Gorman
(b) Address 2202 E. Hoffman Street

17 (a) Burial (b) Date thereof 9/20/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. D. Means Mortuary
(b) Address 805 N. Calvert St. Baltimore Md.

19 (a) SEP 19 1947 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18 1947, at 3:15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 11 1947 to Sept. 18 1947 and that I last saw him alive on Sept. 17 1947.

Immediate cause of death Sudden Cardiac failure.

Due to Recurrent coronary occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul O. Mannix, M. D.
Address Bon Secours Hosp. Date signed 9/18/47

VS 180

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

55242

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G55242

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 900 Warwick Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Blumstein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Ena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 48 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual Occupation: Grocer

11. Industry or business

FATHER
12. Name —
13. Birthplace Russia

MOTHER
14. Maiden Name —
15. Birthplace Russia

16 (a) Informant: Ena Blumstein
(b) Address: 900 Warwick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/19/47 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Vernon
Location: Hebrew Herring Run

18 (a) Funeral director: Jack Lewis Bros
(b) Address: 2102 Eutaw Place

19 (a) SEP 19 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1947 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/31 1947 to 9/19 1947. and that I last saw h[illegible] alive on 9/19 1947.

Immediate cause of death	Duration
Acute coronary occlusion	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Norman Mann M. D.
Address: Sinai Hosp Date signed 9/19/47

PERSON WHO FILLS IN CERTIFICATE, WITH UNDERLINING INK. Every item or information should be carefully supplied. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G55243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1332

Registered No. G55243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) less than 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 St Paul St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William L. Redmond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 12 1888

8. AGE: Years	Months	Days	If less than one day
59	1	6	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Wm. J. Redmond
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Lilly Peterson
15. Birthplace Baltimore Md

16 (a) Informant Rose Myers (Hospital Records)
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-20-47 (month) (day) (year)
(c) Cemetery or crematory St Mary's (Stamped)
Location Baltimore Md

18 (a) Funeral director Frank H. Peetz
(b) Address 1434 36 St

19 (a) SEP 19 1947 (Date rec'd by Registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 Sept 1947, at 6:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 17 Sept 1947 to 18 Sept 1947 and that I last saw h[illegible] alive on 18 Sept 1947.

Immediate cause of death Acidosis

Due to Anuria

Due to Cyanide poisoning - self inflicted

Other Conditions Hydronephrosis bilateral

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None

Duration
Unknown
1-2 yrs
2

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard Acarey M. D.
Address Mercy Hospital Date signed 9-18-47

VS 150

G55244

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G55244

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 101 Calhoun ST.
(c) Hospital or institution: Fallon Hosp — 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or town 3019 W North Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. Balt. Md.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Regina Stein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Jacob Stein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16 1860

8. AGE: Years 87 | Months 2 | Days 2 | If less than one day hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Michael Swing
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Germany

16 (a) Informant Miss Marie Stein, daughter
(b) Address 3494 Dolfield Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (Date rec'd by Registrar) SEP 19 1947 Interim for Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/18 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/13 1947 to 1947, and that I last saw h.. alive on 9/18 1947.

Immediate cause of death: Myocardial Failure

Due to: Fractured Femur

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration: 36 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 8/13/47 15/6 M
(c) Where did injury occur? Car Balto (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury: Slipped & fell to floor

23. Signature Howard J. Mahaney, M.D.

Address Fallon Hosp. Date signed 9/18 M. D.

Howard J. Mahaney, M.D.

TEARING THIS CERTIFICATE, WHICH MUST NOT BE DONE UNDER PENALTY OF LAW, will destroy item of information found to be extremely important. Physicians: please write the causes of death clearly and legibly.

G55245

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 935

G55245 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1815 N. Regester St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No 1815 N Regester St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clyde S. Schoppert Sr

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife April 10th 1877
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10th 1877

8. AGE: Years	Months	Days	If less than one day
70	5	8	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Marquee
11. Industry or business Rowland's Turkish Bath

FATHER
12. Name Wm P. Schoppert
13. Birthplace Va

MOTHER
14. Maiden Name Elizabeth Shawn
15. Birthplace Md

16 (a) Informant Mrs. R. Schoppert
(b) Address 1815 N. Regester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Gen Delfe

18 (a) Funeral director Lee S. Crook
(b) Address 701-03 N. Baltimore Pkwy

19 (a) SEP 19 1947 (Date rec'd, Registrar) Huntington-Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18th 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947 to Sept. 18 1947 and that I last saw him alive on Sept. 17 1947.

Immediate cause of death	Duration
Myocardial Insufficiency	4 days
Due to Myocarditis	6 mos.
Due to Enlarged Lymphatic Glands	6 mos
Other Conditions Chronic Laryngitis	8 mos

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas J Mark M. D.
Address 892 E 22nd Date signed 9/19/47

VS 150

X

G55246

BALTIMORE CITY HEALTH DEPARTMENT

FARLOW CERTIFICATE OF DEATH

95B

Registered No. G55246

Every item of information should be carefully supplied. Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: Elmhurst Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore Pikesville (If outside city or town limits, write RURAL and give town)
(d) Street No. Orchard Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Andrew Peter Farlow

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widower

6 (b) Name of husband or wife Mary Ellen Farlow Deceased – 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 15-1880

8. AGE: Years	Months	Days	If less than one day
67	7	1	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business retired

FATHER
12. Name John Farlow
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Anna Dillion
15. Birthplace Pennsylvania

16 (a) Informant Stella Kaylor
(b) Address Orchad Rd. Pikesville, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 20-47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md

18 (a) Funeral director Frank H. Newell
(b) Address Pikesville, Md.

19 (a) SEP 19 1947 (Date rec'd by registrar) (b) Wallington for Williams, M.D. Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 1947 at 2 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1946 to Sept 16 1947 and that I last saw h~~im~~ alive on Sept 14 – 1947

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Rheumatic Heart Disease	
Due to Advanced Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis Jacob M. D.
Address 1700 Eutaw Pl. Date signed Sept. 18-1947 (DR)

G55247

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G55247

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1900 Maryland Ave.
(c) Hospital or institution:
17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1900 Maryland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carolyn E. Hill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fenale	White	Widowed

6 (b) Name of husband or wife Dr. Norman F. Hill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1850

8. AGE: Years	Months	Days	If less than one day
96	8	25	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Joseph K. Roberts
13. Birthplace Calvert Co., Maryland

MOTHER
14. Maiden Name Amelia Williams
15. Birthplace Calvert Co., Maryland

16 (a) Informant Mr. Norman F. Hill
(b) Address 1900 Maryland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location Baltimore

18 (a) Funeral director H. W. Measerson
(b) Address 805 N. Calvert street,

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

SEP 19 1947

VS 50

MEDICAL CERTIFICATION

20. DATE OF DEATH September 19 1947, at 2.15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2, 1946, to Sept. 19, 1947, and that I last saw her alive on Sept. 19, 1947.

	Duration
Immediate cause of death: Broncho-Pneumonia	1 week.
Due to: Generalized tuberia-sclerosis	Years?
Due to: ~	
Other Conditions: ~	

(Include pregnancy within 3 months of death)
Date of operation None.
Major findings of operation: "
of autopsy: "

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ~
(b) Date of occurrence ~ at ~ M
(c) Where did injury occur? ~
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ~ While at work? ~
(Specify type of place)
(e) Means of injury ~
23. Signature Frank M. Agelon M. D.
Address 2701 Calvert St. Date signed Sept. 17, 47

X

5248

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G55248
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address West Baltimore General
(c) Hospital or institution: Hospital
Rayner and Dukeland, Aves.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 Da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (24)
(If outside city or town limits, write RURAL and give town)
(d) Street No. Back River Boat Yard. Island Pt. Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME anna Kalb

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Matther C. Kalb

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14, 1892

8. AGE: Years 54 | Months 11 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name J. J. Conroy
13. Birthplace

MOTHER
14. Maiden Name Anna ?
15. Birthplace

16 (a) Informant Matthew C. Kalb
(b) Address Back River Boat Yord, Island, Pt. Rd. Balto.24.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 20 47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Road

18 (a) Funeral director Lilly and Zeiler, Inc.
(b) Address 403 S. Wolfe, St. Balto.

19 SEP 20 1947 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sep. 17 1947, at 5 00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sep. 5 1947 to Sep. 17 1947 and that I last saw h[illegible] alive on Sep. 17 1947

Immediate cause of death	Duration
Toxemia	
Due to Gangrene of buttocks	
Due to Rectal abscess	
Other Conditions Diabetes mellitus	

(Include pregnancy within 3 months of death)
Date of operation Sep. 8, 47
Major findings of operation: Rectal abscess
of autopsy: Gangrene of buttock

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Goldstein M. D.
Address [illegible] Date signed 9-11-47

X

055249

BALTIMORE CITY HEALTH DEPARTMENT

ESCHARA CERTIFICATE OF DEATH 120a

Registered No. 055249

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1607 Clifton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1607 Clifton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna C. Escalera

3 (b) If veteran, name war	3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/15/31

8. AGE: Years	Months	Days	If less than one day
15 16	10	3	hr. min.

9. Birthplace Porto Rico (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Augusto Escalera
13. Birthplace Porto Rico

MOTHER
14. Maiden Name Carmen Maria
15. Birthplace Porto Rico

16 (a) Informant Carmen Escalera
(b) Address 1607 Clifton Ave

17 (a) Burial (Burial, cremation, or removal) Date thereof 9/20/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. B. Kelson
(b) Address 1303 Eastern Av

19 (a) SEP 20 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION FS

20. DATE OF DEATH Sept. 18 1947 at 8 a M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Entero-colitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mellus M.D. Medical Examiner.
Date signed 9-18-47

VS 191

655250
AB-76863

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82

655250 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4yrs-11mos-29days
(e) Length of stay in Baltimore (yrs., mos., or days) 23yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 733 Bradley St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced. Seperated

6 (b) Name of husband or wife Nellie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept- 11-1901

8. AGE: Years 46 | Months - | Days 7 | If less than one day hr. min.

9. Birthplace N.C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Louis Brown
13. Birthplace N.C.

MOTHER
14. Maiden Name Sallie Mapson
15. Birthplace N.C.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 22, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N Schroeder St

19 SEP 20 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept-18 1947, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-19- 19 46 to 9-18 19 47, and that I last saw h im alive on 9-18- 19 47

Immediate cause of death: Pulmonary Embolus — Duration: 8 hrs.
Due to: Varicose Ulcers 2° to paraplegia
Due to:
Other Conditions Dysmenorrhea — 2 yrs
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Julius Stolt, Jr. M.D.
Address E. City Hospitals Date signed 9/19/47

VS 150

82D

Please write plainly, using pen and ink. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure to give correct age is especially important.

G55251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52 B

Registered No. G55251

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Redwood Sts
(c) Hospital or institution:
Baltimore, Md (University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
3 days in accident ward. one as hospital admission
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1925 Wilhelm Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Wheeler

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Ida Wheeler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 2nd 1866

8. AGE: Years	Months	Days	If less than one day
80	9	17	hr. min.

9. Birthplace Easton, Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Thomas Wheeler
13. Birthplace Md

MOTHER
14. Maiden Name Sarah Ravel
15. Birthplace Md.

16 (a) Informant Mrs Ida B. Wheeler
(b) Address 1925 Wilhelm St.

17 (a) Burial (b) Date thereof 9/22/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Mem. Park
Location Laurel, Md

18 (a) Funeral director John F. Conway Son
(b) Address 901-03 Hollins St

19 (Date received by registrar) SEP 20 1947 Washington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-19 1947 at 11:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-18 1947 to 9-19 1947, and that I last saw h im alive on 9-19 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Uremia - Cause	
Due to Papillary CA bladder obstructing ureters + Enlarged prostate	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Papillary CA-bladder

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A R Mansbridge M. D.
Address University Hospital Date signed 9-19

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. 055252

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkins Avenue
(c) Hospital or institution: Saint Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Howard
(c) City or town Woodstock
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Mason W Swartz

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-10-1375

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Helen L Swartz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-4-1898

8. AGE: Years	Months	Days	If less than one day
49 49	8	15	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Mason Swartz
13. Birthplace Virginia

MOTHER
14. Maiden Name Clara Harper
15. Birthplace Virginia

16 (a) Informant Mrs Helen Swartz
(b) Address Woodstock Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-22-1947 (month) (day) (year)
(c) Cemetery or crematory Presbyterian Cem
Location Woodstock Md

18 (a) Funeral director F C Ney Mitchell
(b) Address Ellicott City Md

19 SEP 20 1947 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/19 1947, at 9:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/21 1947, to 9/19 1947, and that I last saw him alive on 9/19 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Right lower lobe pneumonia	
Due to Blood dyscrasia — type undetermined	Approx. 1 mo.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: pneumonia + splenomegaly

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert J. Lovelace
Address St. Agnes Hosp. Date signed 9/19/47

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55253

BALTIMORE CITY HEALTH DEPARTMENT

Mc CURN

CERTIFICATE OF DEATH

144a

G55253

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town "Rural" Turners Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 168 Chestnut St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elouise McCurn

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Johnnie McCurn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/29/26

8. AGE: Years	Months	Days	If less than one day
21	5	21	hr. min.

9. Birthplace Cocktill, South Carolina (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER	12. Name Luz Crayne
	13. Birthplace York Co. S. C.
MOTHER	14. Maiden Name Odessa Williams
	15. Birthplace York Co., S. C.

16 (a) Informant Lottie McCurn
(b) Address 168 Chestnut St.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 9/20/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Grove Cem.
Location Rockhill, South Carolina

18 (a) Funeral director Lapsley Sanders
(b) Address 1412 W. Fulton St.

19 (a) SEP 20 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-19- 1947 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 18 1947 to Sept. 19 1947 and that I last saw h[illegible] alive on Sept. 18 1947.

Immediate cause of death Pulmonary Edema & Congestion Lobar Pneumonia Left. Due to Eclampsia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Sept. 19, 1947

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. H. Butler M.D.
Address Provident Hospital Date signed 9/19/47

C55254

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C55254

1137a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 3 1st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 52 days
(e) Length of stay in Baltimore (yrs., mos., or days): 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 39 S. Morley St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: Thomas Hanson C. Penn

3 (b) If veteran, name war: SAW

3 (c) Social Security Account No.: 705-10-7353

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elizabeth F. Derr Penn

6 (c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): Aug. 29, 1879

8. AGE: Years: 68 | Months: 0 | Days: 19 20d | If less than one day: hr. min.

9. Birthplace: Allegheny City, Pa.
(Town, county, and state)

10. Usual Occupation: Retired Railroadman

11. Industry or business: Western Md. R. R.

FATHER
12. Name: James H Penn
13. Birthplace: Pa.

MOTHER
14. Maiden Name: Alice Penn
15. Birthplace: Pa.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9/22/47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) SEP 20 1947 (Date rec'd by registrar) (b) Thomas Jefferson Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 18 1947, at 5:18 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1947, to Sept. 18 1947, and that I last saw him alive on Sept. 18 1947.

	Duration
Immediate cause of death (1) Postoperative state, perineal prostatectomy	
(2) Thrombosis of common iliac and femoral veins (left)	1 wk.
(3) Pulmonary embolism massive right lung	Several Days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation: 8-5-47

Major findings of operation: Benign prostatic hypertrophy

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address: Clinical Director Date signed: 9/19/47

X

Every item or information should be carefully supplied; write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

5255 Hobbs.

BALTIMORE CITY HEALTH DEPARTMENT ✓ G55255
CERTIFICATE OF DEATH 94a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3800 Canterbury Rd.
(c) Hospital or institution: 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3800 Canterbury Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES L. HOBBS

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 215-18-1542

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Inez Hobbs (nee Dever)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 27, 1880

8. AGE: Years 67 | Months 0 | Days 22 | If less than one day hr. min.

9. Birthplace Greensboro, Md.
(Town, county, and state)

10. Usual Occupation County Trust Co. of Md.

11. Industry or business

FATHER
12. Name Wm. Benjamin Hobbs
13. Birthplace Greensboro, Md.

MOTHER
14. Maiden Name Eliza J. Lewis
15. Birthplace Caroline Co.

16 (a) Informant Mr. Charles L. Hobbs
(b) Address 3800 Canterbury Rd.

17 (a) Burial (b) Date thereof 9/22/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greensboro Cem.
Location Caroline Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (Date received by Registrar) SEP 20 1947 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1947 at 6 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 19 1946 to Sept 19 1947 and that I last saw h... alive on Aug 27 1947.

	Duration
Immediate cause of death: Coronary occlusion	20 min
Due to: Coronary disease	18 mo
Due to:	
Other Conditions: Arteriosclerosis	7

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles L. Hubbard M. D.
Address 2220 Garrison Blvd Date signed Sept 19/47

VS 150

G55256

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 8 3a

G55256 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 42 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1705 Gorsuch Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Sophia K. Burrier

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: James L. Burrier

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/30/1887

8. AGE: Years 60 | Months 2 | Days 18 | If less than one day hr. min.

9. Birthplace Stewartstown, Pa.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Robert F. Stabler
13. Birthplace Pa.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Catherine S. Hoffman
(b) Address 1705 Gorsuch Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/20/47 (month) (day) (year)
(c) Cemetery or crematory Evangelical Lutheran Cem.
Location Shrewsbury, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 SEP 20 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-18 1947 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-18 1947 to 9-18 1947 and that I last saw her alive on 9-18 1947

Immediate cause of death: Massive cerebral hemorrhage — Duration

Due to: arteriosclerotic vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E May M. D.
Address St. Joseph's Hosp. Date signed 9-18-47

VS 150

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓46F

Registered No. G55257

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Homewood Apts.
(b) Street address Charles & 31st Sts.
(c) Hospital or institution:
none 12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. Homewood Apts.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas C. Pugh

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 18, 1882

8. AGE: Years	Months	Days	If less than one day
65	---	1	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation chemist
11. Industry or business

FATHER
12. Name Thomas C. Pugh
13. Birthplace N. C.

MOTHER
14. Maiden Name Florence Kingsbury
15. Birthplace N. C.

16 (a) Informant Mrs. Lucy P. Preston
(b) Address Homewood Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 SEP 22 1947 (Huntington Williams M.D. Registrar)
(Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 19 1947, at 6 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 18 1946 to Sept 19 1947, and that I last saw h alive on Sept 18 1947.

Immediate cause of death	Duration
Gastro-intestinal hemorrhage	1 day
Due to Carcinoma + cirrhosis	
Due to of liver.	1 yr.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature M Berman Hood M. D.
Address 2200 Garrison Blvd. Date signed 9/24/47

VS 150

C55258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. C55258

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 East Biddle Street
(c) Hospital or institution:
10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 600 East Biddle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Denson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: W.

6 (b) Name of husband or wife: Ambrose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/24/1872

8. AGE: Years 75 | Months 1 | Days 27 | If less than one day hr. min.

9. Birthplace Austria
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name ?
13. Birthplace

MOTHER 14. Maiden Name ?
15. Birthplace

16 (a) Informant Family
(b) Address 600 E. Biddle St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 9-22-47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Hamilton

18 (a) Funeral director James R. McCauley
(b) Address 130 E. Fort Ave

19 (a) SEP 20 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 18, 1947, at 7:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Myocardiac degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil K. Frey M.D.
Medical Examiner.
Date signed 9-18-47

VS 151

Write the causes of death clearly and legibly. Correct age if apparently impossible. If child, state whether born alive.

55259

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

49a

Registered No. 655259

Every item of information should be carefully supplied. Please write the causes of death clearly and legibly. Physicians: please write especially important. Physicians: please write correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days) 12 days

2. USUAL RESIDENCE OF DECEASED:
(a) State N. J. (b) County.....
(c) City or town Atlantic City
(If outside city or town limits, write RURAL and give town)
(d) Street No.....
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) **FULL NAME** Sophie Katz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 21, 1875

8. AGE: Years 72 | Months 7 | Days 28 | If less than one day ..... hr. ..... min.

9. Birthplace Port Deposit, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Kaufman Katz
13. Birthplace Germany

MOTHER
14. Maiden Name Henrietta Tannenbaum
15. Birthplace Bavaria

16 (a) Informant Miss Rebecca Katz
(b) Address Atlantic City N.J.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/21/42 (Month) (day) (Year)
(c) Cemetery ~~or crematory~~ Ohel Shalom
Location Balto. Md.

18 (a) Funeral director Harris Sondheim Son
(b) Address 902 Eutaw Place

19 (a)..... (b) Huntington Williams, M.D. Registrar
(Date rec'd by Registrar) SEP 20 1942

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18, 1942, at 3.22 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 6 1942, to Sept 18 1942 and that I last saw h[illegible] alive on Sept 18 1942.

Immediate cause of death	Duration
Cachexia	3 mth.
Due to Carcinomatosis	3 mth.
Due to Primary Ca. ? Ovary ?	3 mth. ?
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Oscar Kolman

Address Sinai Hospital Date signed 9/18/42 M. D.

X

G55260

JL - 113830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G55260

Every item of information should be carefully supplied. Please write the causes of death clearly and legibly. Physicians: please write PLAINLY, WITH UNFADING INK. Be correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 502 S. Streeper St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Waudby (Charles Henry Waudby)

3 (b) If veteran, name war: No.

3 (c) Social Security Account No. 216-01-1885

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Margaret E. (Beeks)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1885

8. AGE: Years	Months	Days	If less than one day
62	7	8	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Millwright
11. Industry or business Canton Lumber Co.

FATHER
12. Name John Waudby
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) SEP 20 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18 19 47 at 6.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 15, 1947 to Sept. 18 1947, and that I last saw h. im alive on Sept. 18 19 47.

Immediate cause of death	Duration
Bronchopneumonia	
Due to following Cerebral Vascular Hemorrhage	
Due to Hypertension Cardio-Vascular disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Asked

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William H. Kahler M. D.
Address Balt. City Hosp. Date signed 9-20-47

655261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30c

Registered No. 655261

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town RD #1, Woodbine
(If outside city or town limits, write RURAL and give town)
(d) Street No.....
(If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Wilbur H. Devilbiss

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Widowed

6 (b) Name of husband or wife Mrs. Edna M. Hewitt Guardian if child, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
68			....hr. ....min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name.....
13. Birthplace

MOTHER
14. Maiden Name.....
15. Birthplace

16 (a) Informant Katherine R. Thomas.
(b) Address Carroll Co Welfare Dept.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-22-47 (month) (day) (year)
(c) Cemetery or crematory Middleburg Meth
Location Middleburg Carroll Co. Md

18 (a) Funeral director E. M. Waltz
(b) Address Winfield Md.

19 (a) SEP 20 1947 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-19 1947 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-9 1947 to 9-19 1947, and that I last saw him alive on 9-19 1947.

Immediate cause of death Cerebral Vascular Accident — Duration .....

Due to Central Nervous System Lues. — Duration .....

Due to ..... — Duration .....

Other Conditions Arteriolitis - thyroid Prost. adenoma (Terminal) — Duration .....
(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Calvin B Bearman M. D.
Address Univ. Hosp. Date signed 9-19-47

G55262

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G55262

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 708 Mura Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 708 Mura Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Neary

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Catherine McIvoy
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) June 18, 1874

8. AGE: Years	Months	Days	If less than one day
73	3	0	....hr. ....min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business City- Pipe caulker

FATHER
12. Name Thomas Neary
13. Birthplace Ireland

MOTHER
14. Maiden Name Sara Flanagen
15. Birthplace Ireland

16 (a) Informant Mrs. Neary
(b) Address 708 Mura Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 22/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 900 East Biddle Street

19 (a) SEP 20 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18 19[illegible] at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3 Sept 1947 to 18 Sept 1947 and that I last saw h[illegible] alive on 18 Sept 1947.

Immediate cause of death	Duration
Uremia	4 Days
Due to carbo-vascular renal disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Silverfield M. D.
Address 714 E Preston Date signed Sept 20 1947

X

655263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1 83

Registered No. 655263

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street.
(c) Hospital or institution: 6

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2127- E. Fairmount Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Schrenker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Florence Schrenker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12, 1913

8. AGE: Years	Months	Days	If less than one day
33	9	6 7	hr. min.

9. Birthplace Baltimore Co.Md.
(Town, county, and state)
10. Usual Occupation Truck Driver
11. Industry or business Baltimore Transfer

FATHER
12. Name John Schrenker
13. Birthplace Germany

MOTHER
14. Maiden Name Agnes Kunkel
15. Birthplace Baltimore City

16 (a) Informant George Schrenker
(b) Address Belair Rd. Fullerton, Md.

17 (a) Burial (b) Date thereof Sept. 20, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~cemetery~~ St. Joseph's.
Location

18 (a) Funeral director Lorsch Funeral Home
(b) Address 7401 Belair Rd

19 SEP 20 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19, 1947, at 4.20 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH (a) Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-19-47 at 4 p. M. 3/2
(b) Where did injury occur? Found Harbor-Falls Rd. & Lancaster Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Found drowned.

23. Signature Earl Royer M.D.
Medical Examiner
Date signed 9-20-47

VS 181

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55264

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G55264

Every item of information should be carefully written the causes of death clearly and legibly. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5003 Alhambra Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5003 Alhambra Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Evelyn K. Bauer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife J. Harry Bauer
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1880

8. AGE: Years	Months	Days	If less than one day
67	1	8	____ hr. ____ min.

9. Birthplace Blackwell, Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John George
13. Birthplace Va.

MOTHER
14. Maiden Name Elizabeth Varden
15. Birthplace Va.

16 (a) Informant J. Harry Bauer
(b) Address 5003 Alhambra Ave.

17 (a) Burial (b) Date thereof 9 22 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Baltimore, Md.

18 (a) Funeral director A. R. Slade
(b) Address 4907 York Rd.

19 (a) Sept 20 1947 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/18 1947, at 10.30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/13 1947, to 9/18 1947, and that I last saw h[illegible] alive on 9/18 1947.

Immediate cause of death Coronary occlusion. — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Willis Guyton M.D.
Address 3963 Greenmount Ave. Date signed 9/19/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

655265

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. 655265

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 211 N. Carey St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 211 N. Carey St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Arugunes.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race C

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Richard St.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1, 1886

8. AGE: Years 61 | Months 6 | Days 17 | If less than one day hr. min.

9. Birthplace Washington, D.C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James Kenner.
13. Birthplace Culpepper, Va.

MOTHER
14. Maiden Name Kissold Smith
15. Birthplace Lancaster Co. Va.

16 (a) Informant Virginia Jordon,
(b) Address 211 N. Carey St.

17 (a) Motor (Burial, cremation, or removal) (b) Date thereof 9 22 1947.
(month) (day) (year)

(c) Cemetery or crematory Antioch Baptist.
Location Salisda, Virginia.

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 S Schroeder St

19 (a) SEP 24 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18 1947, at 8:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 17 1947 to Sept 18 1947, and that I last saw h[illegible] alive on Sept 18 19 47

Immediate cause of death Uremia — Duration Past

Due to Hypertension Cardiac

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address 411 N. Johnson St. Date signed 9-20-47

X

655266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. 655266

Every item of information should be carefully supplied. Please write the causes of death clearly and legibly. Physicians: please write; correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2236 Lake Ave-13
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2236 Lake Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY FRISBIE

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Charles H. Frisbie
6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1873

8. AGE: Years	Months	Days	If less than one day
73	11	3	..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name John Schelt
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine---
15. Birthplace Germany

16 (a) Informant Edgar L. Frisbie,
(b) Address 2236 Lake Ave-13

17 (a) Burial (b) Date thereof Sept. 22, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.,

19 (a) SEP 20 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18, 1947, at 3:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1946 to Sept. 18 1947
and that I last saw her alive on Sept 18 1947.

Immediate cause of death	Duration
Cancer of Stomach & Hemorrhage	5 yrs
Due to Chronic Endocarditis	10 yrs
Due to Mitral Stenosis	10 yrs
Other Conditions Arterial Sclerosis	

(Include pregnancy within 3 months of death)
Date of operation 0
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide 0
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Ed. L. Zimmerman M. D.
Address 9855 Harford Rd. Date signed 9/19/47

X

55267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 937

Registered No. G55267

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4702 Harford Road,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 Mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Wicomico
(c) City or town Bivalve
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Addie Louisa Messick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife James I. Messick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1869

8. AGE: Years	Months	Days	If less than one day
78	6	24	hr. min.

9. Birthplace Wicomico Co. Md.
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Esau Larmore
13. Birthplace Maryland

MOTHER
14. Maiden Name
15. Birthplace Maryland.

16 (a) Informant Wm. J.F. Messick
(b) Address Bivalve, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/47 (month) (day) (year)
(c) Cemetery or crematory Methodist Prot. Chu rch
Location Bivalve, Md.

18 (a) Funeral director C.G. Messick,
(b) Address Bivalve, Md.

19 (a) SEP 20 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19, 1947; at 5P/M M

21. I certify that death occurred on the date above stated; that I attended deceased from 1937 to 9/19 1947.
and that I last saw h alive on 9/19 1947

Immediate cause of death: Cerebral Hemorrhage
Due to: Chronic Myocarditis

Duration: 3 months

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wesley D. Tuttle
Address 333 E. Baltimore Date signed 9/30/47 M.D.

C55268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. C55268

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 N. Caroline ST.
(c) Hospital or institution: ST. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County St. Mary's
(c) City or town Ridge
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Cornelia Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/18/89

8. AGE: Years 58 | Months 6 | Days 2 | If less than one day ..... hr. ..... min.

9. Birthplace Ridge, Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Not known
13. Birthplace

MOTHER
14. Maiden Name Not known
15. Birthplace

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (b) Date thereof 9-22-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location Ridge, Md.

18 (a) Funeral director Pius R. Robinson
(b) Address Dameron, Md.

SEP 20 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-20- 1947, at 9:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-3- 1947, to 9-20- 1947, and that I last saw her alive on 9-20-1947.

Immediate cause of death Cardiac failure — Duration

Due to Carcinomatosis

Due to Carcinoma of breast left.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John B. Welle M. D.
Address St. Joseph's Hospital Date signed

VS 150

X 1

PRINT NAME PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

055269

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No. 055269

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5928 Bertram Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5928 Bertram Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM O. MOORE

3 (b) If veteran, name war

3 (c) Social Security Account No. 238-07-2912

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Kate Taylor Moore
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1884

8. AGE: Years	Months	Days	If less than one day
63	3	25	hr. min.

9. Birthplace North Carolina
(Town, county, and state)
10. Usual Occupation General Representative
11. Industry or business British-American Tobacco Co

FATHER
12. Name Michael M. W. Moore
13. Birthplace North Carolina

MOTHER
14. Maiden Name - Oldham
15. Birthplace North Carolina

16 (a) Informant Mrs. Kate T. Moore wife
(b) Address 5928 Bertram Ave.

17 (a) Removal (b) Date thereof 9/20/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Durham, N. C.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 20 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to 19 Sept 1947 and that I last saw him alive on 19 Sept 1947

Immediate cause of death	Duration
Bronchogenic Carcinoma	1 yr
Due to	
Due to	
Other Conditions Inanition + Cachexia	

(Include pregnancy within 3 months of death)

Date of operation Nov 1946, Explor. Thoracotomy → Bronchogenic Cervic Carcinoma, Inoperable
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. T. Callahan Jr M. D.
Address 1011 Calvert St Date signed 20 Sept 1947

V S 150

Every item of information should be carefully supplied. Use ink or indelible pencil, and write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G55270 — Registered No. 157 G55270

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State ~~Md~~ N.J. — (b) County
(c) City or town Elizabeth N.J. (If outside city or town limits, write RURAL and give town)
(d) Street No. 645 Delfield ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: James Joseph Letters

3 (b) If veteran, name war: --
3 (c) Social Security Account No. --
4. Sex: Male — 5. Color or race: White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1-21-44
8. AGE: Years 3 | Months 7 | Days 28 | If less than one day ___ hr. ___ min.
9. Birthplace N. J. (Elizabeth) (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name Joseph Letters
13. Birthplace Scotland
MOTHER 14. Maiden Name Mary Armstrong
15. Birthplace England
16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/23/47 (month) (day) (year)
(c) Cemetery or crematory Graceland Mem. Pk.
Location Kenilworth, N. J.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
19 (a) 1947 (Date rec'd by registrar) (b) Wellington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-19-47 at 1020 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-18-47 to 9-19-47. and that I last saw him alive on 9-19-1947.

Immediate cause of death Cardiac Failure — Duration Sudden
Due to
Due to
Other Conditions Tetralogy of Fallot / Tetralogy of Fallot

(Include pregnancy within 3 months of death)
Date of operation 19-Sept-47
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James R. Canizaro
Address Johns Hopk. Hosp Date signed 9-20-47

VS 150

TYPE WHITE LEAD, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55271
434942

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G55271 Registered No. 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Frederick,
(c) City or town Thurmont.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Omer J. Dubel.

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 213-18-0685

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Ethel Dubel
6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) 1-12-98

8. AGE: Years 49 | Months 8 | Days 7 | If less than one day ..... hr. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Mayor and fur. Store clerk
11. Industry or business

FATHER
12. Name Tyson Dubel
13. Birthplace Melville Md.

MOTHER
14. Maiden Name Amanda Delauter
15. Birthplace Melville Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Sept 22-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Blue Ridge Cem
Location Thurmont Md

18 (a) Funeral director W L Creager & Son
(b) Address Thurmont Md

19 (a) ..... (b) .....
(Date rec'd by registrar) Registrar

SEP 1 1947
VS 150 Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 20 1947 at 12 06 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-8- 1947 to 9-20- 1947 and that I last saw him alive on 9-20- 1947.

Immediate cause of death	Duration
Uremia + hypertensive encephalopathy	7 wks
Due to malignant hypertension	
Due to nephrosclerosis	
Other Conditions Pulmonary tbc - minimus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: on above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Sisson M. D.
Address Johns Hopkins Hosp. Date signed 20 Sept 47

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G55272

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

127a G55272 (per) Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~3405 E. 34th St.~~
(c) Hospital or institution: Union Memorial Hosp., Balto Md 9

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5+ yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ~~Baltimore~~
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3405 ~~E. 34th St.~~, Greenmount Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Elijah Hall

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Emma Jordan Hall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-8-1865

8. AGE: Years 82 | Months 4 | Days 17 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Co. Md
(Town, county, and state)

10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name George Hale
13. Birthplace Maryland Balto Co.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. John Hale
(b) Address Cockeysville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-23-47 (Month) (Day) (Year)
(c) Cemetery or crematory Rosedale Hall
Location Towson, Md.

18 (a) Funeral director Taylor & Brooks
(b) Address Sparks, Md.

SEP 21 1947 (Date rec'd by registrar) (b) Registrar

VS 150 Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-20 1947, at 8:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-7 1947, to 9-20 1947 and that I last saw h.m alive on 9-20 1947.

Immediate cause of death	Duration
Carcinomatosis of Colon (7 days post-op)	
Due to	
Due to	
Other Conditions Arteriosclerotic heart disease (Include pregnancy within 3 months of death)	

Date of operation 9-9-47 & 9-17-47
Major findings of operation: Cholecystitis (9-9-47); Extensive (9-17-47)
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence ... at ... M
(c) Where did injury occur? ... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work? ... (Specify type of place)
(e) Means of injury

23. Signature R G Chambers M.D.
Address Union Memorial Hospital Date signed 9/25/47

X

G55273 — BALTIMORE CITY HEALTH DEPARTMENT — G55273

CERTIFICATE OF DEATH 1947

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10-2
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 111 Wilmoot Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME BORISS ~~[illegible]~~ FREEDMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Bella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: 63 Years | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Bernard Freedman
(b) Address 2612 Forest Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-21-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Levy Inc
(b) Address 2160 Eutaw Place

19 1947 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/19 1947 at 2:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-16 1947 to 9-19 1947 and that I last saw him alive on 9/19 1947.

Immediate cause of death	Duration
Myocardial Infarction	2 days.
Due to Coronary Occlusion	10 days.
Arteriosclerotic H.D.	—
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 9-19-47 at 7:45 A M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Oscar Kerbel M. D.
Address Sinai Hospital Date signed 9/19/47

Huntington Williams, Md

G55274

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

G55274 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2421 St Paul St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard Lipsitch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bertha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1906

8. AGE: Years 41 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Musician

11. Industry or business

FATHER — 12. Name Harry
13. Birthplace New York

MOTHER — 14. Maiden Name Jennie
15. Birthplace Newyork

16 (a) Informant Sidney Lipsitch
(b) Address 3308 Auchentoraly Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-21-47 (month) (day) (year)
(c) Cemetery or crematory United Hebrew
Location Washington Boulevard

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) [illegible] (b) [illegible]
(Signature of person who rec'd by registrar)

Sep 21 [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-19- 1947, at 8:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-9- 1947 to 9-19 1947, and that I last saw him alive on 19 Sept 1947.

Immediate cause of death: Cardio-Respiratory Failure — Duration:
Due to: Ca. of Pancreas & Metastasis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation 19 Aug 47
Major findings of operation: 19 Aug 47 Ca Pancreas
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Philip H. Lerman M. D.
Address Sinai Hosp. Date signed 9 Sept

X

DO NOT USE WRITE FIRMLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55275

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

✓ G55275 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3820 Beech Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3820 Beech Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lillian Arthur Risner

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4 Sex: Female | 5 Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: C. C. Risner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12-1872

8. AGE: Years 74 | Months 9 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore Co. Maryland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name John Arthur
13. Birthplace New York

MOTHER
14. Maiden Name Sallie Cox
15. Birthplace Ohio

16 (a) Informant C. C. Risner
(b) Address 3820 Beech Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 22-1947 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Mem. Park
Location Howard Co. Maryland

18 (a) Funeral director Durgee Funeral Home
(b) Address 3631 Falls Road

19 (a) (b) Filed by registrar Lington Williams, M.D.

SEP 21 1947

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 20- 1947, at 4.05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1946 to Sept 20 1947. and that I last saw h[illegible] alive on Sept 19 1947.

Immediate cause of death: Myocarditis
Due to: Hypertension
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration
1 year
15 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert M. Frater M. D.
Address 2824 St. Paul St Date signed Sept 20-47

X

DURING WHITE LEADER, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55276 BALTIMORE CITY HEALTH DEPARTMENT G55276
Registered No.

CERTIFICATE OF DEATH 43 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division ST
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 522 McMechen ST
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country None

3 (a) FULL NAME Jesse Blanks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race Negro

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Virginia Blanks

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/25/1905

8. AGE: Years 42 | Months 4 | Days 26 | If less than one day hr. min.

9. Birthplace Uniontown Pa.
(Town, county, and state)

10. Usual Occupation Shipping Clerk

11. Industry or business

FATHER
12. Name Downey Blanks
13. Birthplace Mecklenburg Co. Va

MOTHER
14. Maiden Name Susan Truman
15. Birthplace Uniontown Pa

16 (a) Informant Mrs. Virginia Blanks
(b) Address 522 McMechen St.

17 (a) Burial (b) Date thereof Sept. 21, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Chas. Sylvester St. Hallett
(b) Address 1631 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.
SEP 21 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/18 1947 at 5:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/8 1947 to 9/18 1947 and that I last saw him alive on 9/18 1947.

Immediate cause of death Cerebral thrombosis — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. Arnfield M. D.
Address 718 Dolphin St. Date signed 9-26-47

X

G55277

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G55277

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2503 Barclay St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2503 Barclay St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Charles Kranz

3 (b) If veteran, name war: WW

3 (c) Social Security Account No. 220-14-4947A

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lillie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1878

8. AGE: Years 69 | Months 1 | Days 4 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Printer Retired

11. Industry or business

FATHER
12. Name William G Kranz
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Lena Loppe
15. Birthplace Germany

16 (a) Informant Lillie Kranz
(b) Address 2503 Barclay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/47 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Baltimore Md

18 (a) Funeral director Wilson Undertaking Co
(b) Address 1914 Pont St

19 (a) SEP 22 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18 1947, at 9:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 9/18 1947.
and that I last saw h(er) alive on 9/16 1947.

Immediate cause of death: Carcinoma of Colon — Duration: 7

Due to:

Due to:

Other Conditions: Intervesicle Fistula
Cardio-vascular Renal Disease
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph S. Blum M.D.
Address 120 E. Preston St Date signed 9/19/47.

G55278

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

G55278 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 36 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2439 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ada M. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~. W

6 (b) Name of husband or wife Harry A. Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6th 1889

8. AGE: Years 58 | Months 2 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER
12. Name Ogden V. Evans
13. Birthplace N. Y.

MOTHER
14. Maiden Name Sarah E. Perine
15. Birthplace Balto. Co. Md.

16 (a) Informant Mrs. R. J. Tenner
(b) Address 3242 Ebbell Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St.

19 (a) SEP 22 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-19 1947 at 11 50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-14 1947 to 9-19 1947 and that I last saw her alive on 9-19 1947

Immediate cause of death: Uremia — Duration

Due to: Chronic glomerular nephritis

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E May M. D.
Address St. Jos. Hosp. Date signed 9-19-47

VS 150

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C55279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C55279

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5201 Tramore Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5201 Tramore Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emil R Schomburg

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-03-6704

4. Sex M. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Edith Mann Schomburg
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10 - 1884

8. AGE: Years 63 | Months 2 | Days 9 | If less than one day hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Secretary
11. Industry or business Bldg. Loan

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant John A. Kelley
(b) Address 5201 Tramore Rd.

17 (a) Burial (b) Date thereof Sept 20. 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Wm Cook Inc
(b) Address 417 St Paul St.

19 (a) SEP 22 1947 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1946 to 9/19 1947, and that I last saw him alive on 9/17 1947.

	Duration
Immediate cause of death Coronary Occlusion	1 hour
Due to Coronary Sclerosis	
Due to Arteriosclerosis generalized	years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury Heart

23. Signature Wm. L. Henson M. D.
Address 20 E. Preston St. Date signed 9/16/47

VS 150

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V.13B

Registered No. G55280

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount Ave
(c) Hospital or institution:
The Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 600 Evesham Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Marjorie Mann

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20 - 1922

8. AGE: Years	Months	Days	If less than one day
25	3	25	hr. min.

9. Birthplace Maryland Baltimore Co.
(Town, county, and state)
10. Usual Occupation Telephone Operator
11. Industry or business C & P Tel. Co.

FATHER
12. Name William C Mann
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna J Hennick
15. Birthplace Maryland

16 (a) Informant Wm C. Mann
(b) Address 1829 Aisquith St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/47 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Dorsey Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St.

19 (a) SEP 22 1947 (Date received by Local Registrar) (b) Huntington Williams, M.D. Address Church Home Hospital

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 1947 at 5:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 16 1947 to Sept 21 1947, and that I last saw her alive on Sept 21 1947.

Immediate cause of death	Duration
Bilateral Pulmonary Tuberculosis	6 months
Due to Cystic Lesion	
Due to Lung	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Sept 18, 1947
Major findings of operation:
of autopsy: Tuberculosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Vernon H Rohwedder M. D.
Address Church Home Hospital Date signed 9-21-47

VS 150

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special attention to correct age is especially important.

G55281

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13/a

Registered No. G55281

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 615 Bartlett Ave
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 615 Bartlett Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude B. Kauffman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband August Kauffman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 18th 1875

8. AGE: Years	Months	Days	If less than one day
72	6	2	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name William Holland
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Bumpers
15. Birthplace Va

16 (a) Informant Gladys Wolf
(b) Address Mt. Airy Md.

17 (a) Burial (b) Date thereof 9/24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul st.

19 (a) SEP 22 1947 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 20th 1947, at 7:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5 Sept 1946, to 20 Sept 1947, and that I last saw h[illegible] alive on 20 Sept 1947.

Immediate cause of death	Duration
Left ventricular failure with pulmonary edema	1 week
Due to Cardio-Vascular-Renal disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel Silverfarb M.D.
Address 714 E. Preston Date signed 20 Sept 1947

X

G55282 Duplicate

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G55282

107

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N Y (b) County
(c) City or town Flushing, L.I.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 164-07 32nd Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ORTLEIB Elsie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: George

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) about July 23 1884

8. AGE: Years 63 | Months 1 | Days 28 | If less than one day hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Gustav Zeller
13. Birthplace Germany

MOTHER
14. Maiden Name Lydia
15. Birthplace Germany

16 (a) Informant George A Ortleib
(b) Address Flushing L.I. N.Y.

17 (a) Cremation (b) Date thereof 9/22/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn
Location New York City

18 (a) Funeral director Wilhelm & Son
(b) Address 1217 Pont St

19 (a) SEP 22 1947 (b) Huntington Willis
(Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/21 1947, at 5:46 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 14 1947 to Sept. 21 1947 and that I last saw h[illegible] alive on Sept. 21 1947.

Immediate cause of death: Respiratory Failure. — Duration

Due to: Broncho-Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Bronchopneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Duvall M.D.
Address University Hosp. Date signed 9/21/47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

55283 Alt # 88644

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G55283
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Nursing Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 821 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby ~~Girl~~ Costner

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex: ~~Female~~ Male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/30/47

8. AGE: Years | Months | Days | If less than one day hr. 20 min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Costner
13. Birthplace North Carolina

MOTHER
14. Maiden Name Mae Evelyn Adams
15. Birthplace South Carolina

16 (a) Informant Mae Costner
(b) Address 821 W Lexington St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location for City Disposal University Medical School SEP 5 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) SEP 22 1947 (Signature of registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 30, 1947, at 1 0/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/30 1947 to 8/30 1947 and that I last saw him alive on 8/30 1947

Immediate cause of death	Duration
Respiratory Failure	
Due to Congenital Atelectasis	
Due to Prematurity	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stewart M. Williams M. D.
Address University Hosp. Date signed 8/31/47

X

G55284

A57348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ Registered No. G55284

159

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address.....

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days).....

(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Charles Co.

(c) City or town La Plata

(If outside city or town limits, write RURAL and give town)

(d) Street No..... (If rural give location)

(e) Citizen of foreign country?..... (Yes or No)

If yes, name country.....

3 (a) FULL NAME Baby Girl Defew

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 8-29-47

8. AGE: Years — | Months 2 | Days 1 | If less than one day: 3 hr. — min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation.....

11. Industry or business.....

FATHER 12. Name Thomas Defew

13. Birthplace Ky.

MOTHER 14. Maiden Name Debra ?

15. Birthplace Tenn.

16 (a) Informant.....

(b) Address JOHNS HOPKINS HOSPITAL

17 (a)..... (b) Date thereof..... (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory.....

Location..... Johns Hopkins Medical Schoo SEP 5 1947

18 (a) Funeral director..... Commissioner of Health

(b) Address.....

19 (a) SEP 22 1947 (Date rec'd by registrar) (b) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-31-47, at 1115 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-29-1947 to 8-31-1947, and that I last saw her alive on 8-31-1947.

Immediate cause of death PREMATURITY — Duration .....

Due to..... — .....

Due to..... — .....

Other Conditions..... — .....

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide.....

(b) Date of occurrence..... at ..... M

(c) Where did injury occur?..... (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)

(e) Means of injury.....

23. Signature William A. Spencer M.D.

Address Johns Hopkins Hosp Date signed 9/1/47

Normal Time

X

V S 150

55285 BC# B-87730

BALTIMORE CITY HEALTH DEPARTMENT ✓ G55285

CERTIFICATE OF DEATH 159

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 12-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1023 W. 36th St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Domin

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced:
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 28 47

8. AGE: Years X | Months X | Days X | If less than one day: 0 hr. 40 min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Bernard Domin
13. Birthplace Santa Monteir Cal.

MOTHER
14. Maiden Name Alma Zisimos
15. Birthplace Balto Md.

16 (a) Informant Mrs Alma Domin
(b) Address 1023 W. 36th St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 5 1947

18 (a) Funeral director Commissioner of Health
(b) Address

SEP 22 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/28/47 at 7 39 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/26/ 1947 to 8/28 1947, and that I last saw him alive on 8/28 1947.

Immediate cause of death Respiratory failure — Duration
Due to Congenital Atelectasis
Due to Prematurity
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stewart M. Williamson M. D.
Address University Date signed Sept 2 47

X

55286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G55286
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Carroll County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. Springfield State Hosp.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hattie Michel

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Hirsch Michel
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta Wilshusen
15. Birthplace Germany

16 (a) Informant Official State
(b) Address Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 8 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) SEP 9 1947 (Date received by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/3 1947, at 8 40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/2 1947 to 9/3 1947, and that I last saw her alive on 9/3 1947

Immediate cause of death Metastatic Carcinoma of Head of Pancreas with

Due to Acute Intestinal Obstruction due to Carcinoma of Pancreas with Metastases to Liver & other organs.

Due to Acute Uremia

Other Conditions Arteriosclerotic Cirrhosis of Kidneys

(Include pregnancy within 3 months of death)

Date of operation 9/2/47

Major findings of operation: Metastases of Carcinoma in Pancreas & Liver & Ascites of abdomen

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. B. Peck, Jr.

Address Univ. Hosp. Date signed 9/3/47 M.D.

G55287

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G55287

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1919 Madison ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 605 Hamburg Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Johnson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years	Months	Days	If less than one day
76			hr. min.

9. Birthplace King George County Va (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Sarah anna Miller.
15. Birthplace King George County Va

16 (a) Informant Mrs. Ella Spathers
(b) Address 621-23rd St N.W. Washington D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 14, 19 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn Cemetery
Location Baltimore City

18 (a) Funeral director Joseph A. Lorsch
(b) Address 66 West Baltimore St

SEP 22 1947 Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20 1947 at 1 55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12 Sept 1947 to 18 Sept. 1947, and that I last saw h[illegible] alive on 18 Sept. 1947.

Immediate cause of death: Cardio Resp. failure — Duration: Unknown

Due to: Hypertensive Cardio Renal disease.

Due to:

Other Conditions: Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Tommarello M.D.
Address 910 W. Lombard St Date signed 20 Sept. 1947.

VS 150

55288 BALTIMORE CITY HEALTH DEPARTMENT ✓ G55288

CERTIFICATE OF DEATH 179X

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1631 E. Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jessie May Warrell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1909

8. AGE: Years	Months	Days	If less than one day
38			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business None

FATHER
12. Name Harrison
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, [illegible] University Medical School (b) Date thereof SEP 3 1947 (month) (day) (year)
(c) Cemetery or crematory [illegible] SEP 3 1947
Location [illegible]

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) SEP 2 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-15-1947, at 11 35 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Acute fatty degeneration of liver

Due to Carbon-tetrachloride poisoning.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8/11/47 at ? 3/1 M.
(b) Where did injury occur? 1631 E. Baltimore St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Ingestion of Poison.

23. Signature [signature] M.D. Medical Examiner.
Date signed

X

G55289

DCH B 87161

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

157E

Registered No. G55289

write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 Druid Hill Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DAVID DASHIELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/15/47

8. AGE: Years | Months | Days: 4 | If less than one day: hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School SEP 3 1947

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) SEP 2 1947 (Date received by registrar) Thurlow Tom Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19, 1947, at 4.46 P.M.

21. I certify that I took charge of the remains described above, held an ~~Inquest~~ Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Congenital heart disease (inter-auricular septal defect.)

Due to Partial atelectasis of lungs
Jaundice of the new-born.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature George A. Merrill M.D.
Medical Examiner.

Date signed 8-20-47

X

555290

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 171a

Registered No. 555290

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Saratoga Sts.
(c) Hospital or institution: Franklin Square 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Balto City Hospital
4940 Eastern Avenue
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Cudd

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Elizabeth Mills
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 23 1868

8. AGE: Years	Months	Days	If less than one day
79	3	26	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Charles Henry Rudd
13. Birthplace Md

MOTHER
14. Maiden Name Emma Eichenlaub
15. Birthplace Md

16 (a) Informant Balto City Hosp Records
(b) Address 4940 Eastern Ave

17 (a) Burial (b) Date thereof Sept 22 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Pittsburgh Pa

18 (a) Funeral director Geo L Keyser Jr
(b) Address 512 Hollins St

19 (a) SEP 22 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19th 1947, at 81 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull & intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-19-47 at 5:36 P.M. 18/2
(b) Where did injury occur? Saratoga & Arnold Sts
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Fell down & struck by motor car

23. Signature [signature] M.D.
Medical Examiner.
Date signed 9-20-47

Correct age is especially important. Physicians, please write distinctly.

VS 181

C55291

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48.12

Registered No. C55291

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1609 Patapsco Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1609 Patapsco Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Alice E. Shearer

3 (b) If veteran, name war No — 3 (c) Social Security Account No. No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John L. Shearer
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Jan 6 1901

8. AGE: Years	Months	Days	If less than one day
46	8	12	hr. min.

9. Birthplace Balto
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name John W Brown (CONN)
13. Birthplace Md

MOTHER
14. Maiden Name Alice L Linton
15. Birthplace York Penn

16 (a) Informant John L Shearer
(b) Address 1609 Patapsco

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 23 1947 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Balto

18 (a) Funeral director A. Leonard Eckhardt
(b) Address 1400 Eastern

19 (a) SEP 22 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 22 1947 at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947 to Sept 22 1947, and that I last saw him alive on Sept 22 1947.

Immediate cause of death	Duration
(a) Embolism	3 days
Due to (b) Carcinoma	5 mo
Due to (c) Fx Femur	20 dys
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. C. Campbell M. D.
Address 1044 Hanover Date signed 9/22/47

V S 150

65292 BC# 40574

BALTIMORE CITY HEALTH DEPARTMENT ✓ Registered No. 65292

CERTIFICATE OF DEATH 122 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St Josephs Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1409 N. Bond Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Roy Frank Collier (Roy F. Collier III)

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) 1/23/46

8. AGE: Years 1 | Months 20 | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Roy F. Collier Jr.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Ruth L. Carey
15. Birthplace Delaware

16 (a) Informant Roy F. Collier Jr. (Father)
(b) Address 1409 N. Bond Street

17 (a) Burial **(b) Date thereof** 9/24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Taylor Avenue, Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) SEP 22 1947 (Date rec'd by registrar) Huntington for Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/21/1947 at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/21/1947 to 9/21/1947 and that I last saw h[illegible] alive on 9/21/1947.

Immediate cause of death Cardio-Respiratory failure — Duration Hours 18 hrs.

Due to gangrene of ileum

Due to Intussusception

Other Conditions Post-Op Shock

(Include pregnancy within 3 months of death)

Date of operation 9/21/47

Major findings of operation: Intussusception + gangrene

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stanley B. Klyanovic, M. D.

Address St Josephs Hosp. **Date signed** 9/24/47

VS 150

G55293

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

✓ Registered No. G55293

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5013 Walther Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5013 Walther Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Hecker

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John A. Hecker
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) April 13, 1887

8. AGE: Years 60 | Months 5 | Days 8 | If less than one day: ######## hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name William Doell
13. Birthplace Virginia

MOTHER
14. Maiden Name Louise Weamert
15. Birthplace Maryland

16 (a) Informant Mrs. Gertrude Derringer
(b) Address 5013 Walther Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road, Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) SEP 22 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21st 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1945 to 9/21 1947 and that I last saw her alive on 9/21 1947

Immediate cause of death	Duration
Adenocarcinoma of Ovary	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Helen Doell
Address 5725 Harford Rd. M. D. Date signed 9/24/47

X

V S 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G55294

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G55294 Registered No. 83a

Write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 4-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Unknown (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANDY ANDERSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [illegible]

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business Unknown

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 3 1947 Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) SEP 22 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8, 1947, at 4.50 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Intracranial hemorrhage (subdural)
Edema of lungs
Due to Fat infiltration of liver

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury Found on street

23. Signature George B. Merrill M.D.
Medical Examiner.
Date signed 8-9-47

G55295 B# B 85207

BALTIMORE CITY HEALTH DEPARTMENT ✓ G55295 Registered No.

CERTIFICATE OF DEATH 160a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. Monument St
(c) Hospital or institution Sinai Hosp ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ✓
(c) City or town Baltimore - 31 (If outside city or town limits, write RURAL and give town)
(d) Street No. 413 S. Durham St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anthony Joseph Zawacki

3 (b) If veteran, name war ✓ 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/2/47

8. AGE: Years	Months	Days	If less than one day
NB.		2	hr. min.

9. Birthplace Balto - Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Bernard J. Zawacki
13. Birthplace Balto - Md

MOTHER
14. Maiden Name Lillian E. Staniewicz
15. Birthplace

16 (a) Informant Lillian Zawacki
(b) Address 413 S. Durham St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP [illegible]
18 (a) Funeral director. Commissioner of Health
(b) Address
19 (a) SEP 2 1947 (Date received by registrar) (Signature of registrar)

VS 8

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 5 1947 19—, at 9:08 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 3 1947, to Aug 5 1947, and that I last saw h[illegible] alive on Aug 5 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Unknown cause	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address Sinai Hosp Date signed 8/8/47

X

C55296

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. C55296

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 158 W. West St
(c) Hospital or institution:
23
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs.) mos., or days) 15

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 158 W. West St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Georgia Lomax

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Essex County Va
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Ben Lomax
13. Birthplace Va.

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Beal Bass
(b) Address 158 W West

17 (a) Burial (b) Date thereof 9/22/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Co. Md

18 (a) Funeral director Isaiah L Brown & Son
(b) Address 126 W Montgomery St

19 SEP 22 1947 Pettigrew Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 19 1947, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1947, to Sept 19 1947, and that I last saw her alive on Sept 19 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. D. Taylor
Address 1522 Harlem Ave Date signed 9/22/47

VS 150

FORM WHITE PRINTED, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. correct age is especially important. Physicians: please write

55297

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G55297

A 57496 B 88114 107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 222 S. Carey St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Gary Anderson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-30-47

8. AGE: Years	Months	Days	If less than one day
		12	....hr. ....min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation.....
11. Industry or business

FATHER 12. Name Richard D. Anderson
13. Birthplace Va.

MOTHER 14. Maiden Name Glenn Miller
15. Birthplace Md.

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a).....(b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location Johns Hopkins Medical Schoo SEP 12 1947

18 (a) Funeral director Commissioner of Health
(b) Address.....

SEP 22 1947 Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept - 11 - 1947, at.....M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-6- 1947 to 9-11- 1947 and that I last saw him alive on 9-11- 1947.

Immediate cause of death	Duration
Due to Bronchopneumonia	
Due to tracheoesophageal Fissure	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature [signature]
Address.....Date signed 8-11-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55298 BC# 687433

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

✓ G55298 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division st.
(c) Hospital or institution: Provident Hosp. 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 mm.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 712 W. Lanvale st.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Ross Peterson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 20, 1947

8. AGE: Years | Months | Days | If less than one day: — hr. 17 min.

9. Birthplace Baltimore, md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name James Paul Peterson
13. Birthplace Dothan Ala.

MOTHER
14. Maiden Name Vivian Wilson
15. Birthplace Enterprise Ala.

16 (a) Informant U. Nash R.N.
(b) Address 1514 Division st

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 9 1947

18 (a) Funeral director Commissioner of Health
(b) Address

SEP 22 1947 Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 20 1947, at 2:47 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw him alive on Aug. 20 1947.

Immediate cause of death — Duration

Due to Atelectasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo H Peterson M. D.

Address [redacted] Date signed

President Hosp 4 yrs

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G55299

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State..... (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1944 Annapolis Ave.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Baby Girl Gordon.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 9-9-47

8. AGE: Years | Months | Days | If less than one day: 2 hrs. ..... min.

9. Birthplace md
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER
12. Name Austin Gordon
2.
13. Birthplace

MOTHER
14. Maiden Name Sadie M Kerr
2.
15. Birthplace

16 (a) Informant Regnols.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a)..... (b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location [redacted] SEP 9 1947

18 (a) Funeral director Commissioner of Health
(b) Address.....

19 SEP 22 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS. 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Sept. 9th 1947, at 4.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 1947, to Sept 9 1947, and that I last saw HER alive on Sept 9 1947

Immediate cause of death	Duration
Prematurity	
Due to.....	
Due to.....	
Other Conditions.....	

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature J. Neill Lyon M. D.
Address Johns Hopkins Hospital Date signed Sept 9 1947

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G55300 Registered No.

Please write the causes of death clearly and legibly. Correct age is especially important. Physicians: please write.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1144 N. Strickers St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Calvin Gordon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1925

8. AGE: Years 22 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Everetto Gordon
13. Birthplace Penna.

MOTHER
14. Maiden Name Helen Thompson
15. Birthplace Westmoreland Co. Va.

16 (a) Informant Mrs. Helen Gordon
(b) Address 1144 N. Strickers St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-22-1947 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N. Schroeder St

SEP 22 1947 (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20. 1947, at 2:43 A.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute gastro-enteritis. Pulmonary tuberculosis, Chronic swelling of kidneys

Due to: God's Will

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Earl L. Kruger M.D.
Medical Examiner

Date signed 9-20-47

G55301 AB 688907 BALTIMORE CITY HEALTH DEPARTMENT 159 G55301 Registered No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20Min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 E. Madison Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Dean

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: Col.
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept.7-1947
8. AGE: Years | Months | Days | If less than one day ..... hr. 20 min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Curtis McMurrey
13. Birthplace ?

MOTHER
14. Maiden Name Thelma McCray
15. Birthplace S.C.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 9-8-47 (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (c) SEP 22 1947 (Date received by registrar) (Huntington Williams, M.D.) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7- 1947, at 3.50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-7 1947, to 9-7- 1947, and that I last saw h. im alive on 9-7- 1947.

Immediate cause of death: Pneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address [illegible] Date signed [illegible]

IMPORTANT. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

55302 BC# G87436 BALTIMORE CITY HEALTH DEPARTMENT G55302

CERTIFICATE OF DEATH 161a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division Street
(c) Hospital or institution Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1604 ½ E Eutaw Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Claudia James Brown

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 24, 1947

8. AGE: Years | Months | Days | If less than one day: 19 hr. 51 min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER FATHER
12. Name Herman Charles Brown
13. Birthplace Baltimore, Maryland
14. Maiden Name Delorise Washington
15. Birthplace Baltimore, Maryland

16 (a) Informant Delorise Brown
(b) Address 1604 ½ E Eutaw Street

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 5 1947

18 (a) Funeral director Commissioner of Health
(b) Address
SEP 22 1947 (Date received by registrar) Harry J. Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 25 1947, at 12:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 24 1947, to Aug. 25 1947, and that I last saw h[illegible] alive on Aug 25 1947

Immediate cause of death: atelectasis — Duration: 19 hr 51 m

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 723 Dennison Pl. Baltimore

VS 150

X 9-24-47

G55303 BC# B 87600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160c

G55303 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: President Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Cato
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1614 W. North Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ronald Malcolm Ray

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 28 September 1947

8. AGE: Years	Months	Days	If less than 1 day
—	—	4	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation infant

11. Industry or business

FATHER
12. Name Frederick Ray
13. Birthplace Carthage, N. C.

MOTHER
14. Maiden Name Hypatha Sanders
15. Birthplace Johnston Co., N. C.

16 (a) Informant Hypatha Ray
(b) Address 1614 W. North Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 5 1947

18 (a) Funeral director Commissioner of Health
(b) Address

SEP 22 1947 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 7 September 1947, at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 29 August 1947 to 7 Sept. 1947 and that I last saw h[illegible] alive on 7 Sept. 1947

Immediate cause of death: Bronchopneumonia — Duration 36 hrs.

Due to

Due to

Other Conditions breech presentation

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James D. Carr, M. D.

Address 515 Mosher St Date signed 9.3.47

G55304

BC# B-87441

BALTIMORE CITY HEALTH DEPARTMENT ✓

CERTIFICATE OF DEATH 160a

Registered No. G55304

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution. Balto. Provident Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 9 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1131 Shields Place
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jacqueline Cornelius Watkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Fe | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14, 1947

8. AGE: Years | Months | Days | If less than one day 9 hr. — min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name James Watkins
13. Birthplace Baltimore

MOTHER
14. Maiden Name Beatrice Bailey
15. Birthplace Baltimore, Md.

16 (a) Informant Virginia Nash, R.N.
(b) Address 1514 Division St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 5 1947

18 (a) Funeral director Commissioner of Health
(b) Address
(c) SEP 2 1947 Huntington Williams M.D.
(Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 15 1947 at 8:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 14 1947, to Aug. 15 1947, and that I last saw him alive on Aug. 15 1947.

Immediate cause of death — Duration

Cerebral Hemorrhage

Due to Dystocia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature N. Louise Young M. D.

Address 1130 Druid Hill Ave Date signed 8/24/47

VS 150

X

G55305 Dr. Harbold

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G55305

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5401 Carter Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5401 Carter Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis H. (Henry) Ahl

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife Nellie M. Ahl

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 18, 1873

8. AGE: Years 73 | Months 11 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Francis F. Ahl
13. Birthplace ?

MOTHER
14. Maiden Name Delphine Smith
15 Birthplace ?

16 (a) Informant Mrs. Thomas H. Everett
(b) Address 5401 Carter Avenue, 14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-22-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14.

19 (a) SEP 22 1947 (Date rec'd by registrar) (b) Huntington Williams Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19th, 1947; at M

21. I certify that death occurred on the date above stated; that I attended deceased from April 13 1947 to Sept 19 1947, and that I last saw him alive on Sept 18 1947.

Immediate cause of death Coronary Thrombosis — Duration Sudden

Due to Coronary sclerosis (10 yrs)

Due to Arteriosclerosis

Other Conditions Organ of Bands

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. V. Harbold M. D.

Address 4706 Harford Road Date signed 9-23-47

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Wm. Michel

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

Registered No. 055306

055306

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2924 Riggs Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2924 Riggs Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stanley P. Maxwell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Marcella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1876

8. AGE: Years	Months	Days	If less than one day
71	2	5	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Isaac Maxwell
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Snyder
15 Birthplace ?

16 (a) Informant Mrs. Marcella Luecking
(b) Address 2924 Riggs Avenue

17 (a) Burial (b) Date thereof 9-22-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 ([illegible] registrar) Huntington Williams

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19th, 19 47 at 3.00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 20 1947 to Sept. 19 1947 and that I last saw him alive on Sept 18 1947.

Immediate cause of death	Duration
Generalized Carcinomatosis	6 months
Due to Carcinoma of rectum	4yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Nov. 1943
Major findings of operation: Carcinoma of rectum.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Michel M. D.
Address 2901 Edmondson Ave Date signed Sept 20 1947

G55307

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 B

G55307 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1421 Caroline St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Mary Eustochia O.S.F.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31-1886

8. AGE: Years	Months	Days	If less than one day
61 60	6	9 20	hr. min.

9. Birthplace Baltimore - Md.
(Town, county, and state)
10. Usual Occupation Religious
11. Industry or business Sister of St. Francis

FATHER 12. Name Edwin D. Stevenson
13. Birthplace

MOTHER 14. Maiden Name Emma Jane
15. Birthplace

16 (a) Informant Sr. Mary Ethelberta
(b) Address St Paul's Convent

17 (a) Burial (b) Date thereof 9-23-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto.

18 (a) Funeral director L. J. Cyck
(b) Address 305 Harford Rd

19 SEP 22 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-20 1947 at 10 30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-26 1947 to 9-20 1947 and that I last saw h alive on 19

Immediate cause of death: Carcinoma of bladder — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E May
Address St. Joseph's Hosp. Date signed 9/20/47.

VS 150

X

Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

55308

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a ✓

Registered No. 055308

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 610 S . Clinton Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 b
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 610 S. Clinton Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles C. Kramer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Helen C. Staps
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19/1889

8. AGE: Years	Months	Days	If less than one day
58 57	4	29	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business

FATHER
12. Name James H. Kramer
13. Birthplace Balto

MOTHER
14. Maiden Name Theresa ?
15. Birthplace Balto

16 (a) Informant James H. Kramer (son)
(b) Address 610 S. Clinton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave Ext.

18 (a) Funeral director Lilly & Duker Co
(b) Address 403 S. Wolfe Street

19 (a) SEP 22 1947 (Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/ · 18 1942, at 12° A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1942 to Sept 18 1942, and that I last saw h[illegible] alive on Sept 16 1942.

Immediate cause of death	Duration
Acute Cardiac Failure	
Due to Coronary Occlusion	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address 3503 Fort Ave Date signed 9-22-47 M. D.

VS 150

X

Please write plainly, in ink. Every item should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G55309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G55309

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 907 Whitelock St
(c) Hospital or institution: 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 907 Whitelock St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julius Edlavitch

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Late Beatrice Rebecca
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business Butcher

FATHER
12. Name Morris Edlavitch
13. Birthplace Russia

MOTHER
14. Maiden Name Libby ?
15. Birthplace Russia

16 (a) Informant Sadie Smith
(b) Address 907 Whitelock St

17 (a) Burial (b) Date thereof Sept 22, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mishkin Israel Cemetery
Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) SEP 22 1947 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21 19 47 at 4.35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 19 47 to 21 Sept 19 47
and that I last saw h alive on 21 Sept 19 47

Immediate cause of death	Duration
Jaundice	1 Month
Due to Carcinomatosis Liver	
Due to Ca of stomach	1 yr 6 yr
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 1947
Major findings of operation: Ca of Stomach
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M. D.
Address 1 E Ost Eutaw Place Date signed 21 Sept 1947

X

Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55310

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G55310

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Res 2403 Shirley ave
(c) Hospital or institution: Sinai Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2403 Shirley ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL RAPKIN

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-2642

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Gertrude
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) aug 6. 1885

8. AGE: Years	Months	Days	If less than one day
62	1	15	hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name U.K
13. Birthplace Russia

MOTHER
14. Maiden Name U.K
15. Birthplace Russia

16 (a) Informant Mrs Sidney Rapkin
(b) Address 2403 Shirley ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 23/47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale
Location Philadelphia Rd + Hamilton ave

18 (a) Funeral director Sol Levinson + Bros
(b) Address 1124-26 W. North ave

19 (a) SEP 22 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 20 1947, at 5 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 20 1947, to Sept 21 1947, and that I last saw him alive on Sept 21 1947.

Immediate cause of death	Duration
Acute Coronary Occlusion	
Due to A.S.H.D.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice A. Perelin M.D.
Address Sinai Hosp. Date signed 9/21/47 M.D.

VS 150

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55311

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 11-5183 G55311

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Calvert & 33rd Sts.

(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days

(e) Length of stay in Baltimore (yrs., mos., or days) 3 weeks

2. USUAL RESIDENCE OF DECEASED:

(a) State North Carolina (b) County

(c) City or town Wilmington (If outside city or town limits, write RURAL and give town)

(d) Street No. — (If rural give location)

(e) Citizen of foreign country? ? (Yes or No)

If yes, name country Russia

3 (a) FULL NAME Mr. Harry B. Morris

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 15, 1880

8. AGE: Years	Months	Days	If less than one day
66 67	9	6	____ hr. ____ min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER

12. Name Bernhardt Morris

13. Birthplace Russia

MOTHER

14. Maiden Name Gitna Schorr

15. Birthplace Russia

16 (a) Informant Mrs. Esther Margolis

(b) Address 3813 Barrington Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 22 '47 (month) (day) (year)

(c) Cemetery or crematory Beth Shalom Cemetery

Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros.

(b) Address 1124-26 W. North Ave

19 (a) SEP 22 1947 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21 1947 at 8:31 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1947 to Sept 21 1947 and that I last saw h[illegible] alive on Sept 21 1947.

Immediate cause of death	Duration
Sudden Heart Failure	
Due to Arteriosclerotic Heart Disease	
Due to	
Other Conditions Chronic Pancreatitis	

(Include pregnancy within 3 months of death)

Date of operation Sept. 21, 1947

Major findings of operation: Secondary Eruption of Wound

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John F. Hagan Jr. M. D.

Address Union Mem. Hosp. Date signed 9/24/47

X

G55312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. G55312

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lyndale Home
(c) Hospital or institution:
Belvedere + Greenspring ave
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4218 Reisterstown Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL COHN

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Late Jennie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 78 | Months | Days | If less than one day hr. min. 77

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation
11. Industry or business None

FATHER
12. Name Harry Cohn
13. Birthplace Russia

MOTHER
14. Maiden Name Ida
15. Birthplace Russia

16 (a) Informant Harry Cohn
(b) Address 4912 Dessmore Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 22/47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Young Men's
Location Winder Hill Road

18 (a) Funeral director Sol Levinson + Bros
(b) Address 1124-26 W. North ave

19 (a) SEP 22 1947 (Date rec'd by registrar) (b)

Huntington Woodlawn, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-21 1947 at 6:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-11 1947 to 9-21 1947 and that I last saw h[illegible] alive on 9-21 1947.

	Duration
Immediate cause of death Carcinomatosis abdomen	
Origin undetermined	
Due to	
Due to	
Other Conditions Chron. cardio-vascular	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Nagel M. D.
Address Lyndale Home Date signed 9-24-47

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55313

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. G55313

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 S. Light Street
(c) Hospital or institution: South Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2756 Alameda Blv. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Burns

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-29-88

8. AGE: Years	Months	Days	If less than one day
59	8	21	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name John Taylor
13. Birthplace Balto

MOTHER
14. Maiden Name Sarah Taylor
15. Birthplace Balto

16 (a) Informant Mrs. W.C. Dearinger
(b) Address 2756 Alameda Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Pikesville Highway

18 (a) Funeral director Tully & Tuttle
(b) Address 1038 E. Monument St.

1947 SEP 22 (Date rec'd by registrar) Huntington Willis, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19 1947, at 3 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 18 1947 to Sept 19 1947, and that I last saw her alive on Sept 19 1947.

Immediate cause of death Lobar Pneumonia — Duration

Due to Complication of operation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9-3-47

Major findings of operation: Carcinoma of uterus

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Gilbert Carouge M. D.
Address 6226 Everall Ave Date signed 9-19

VS 150

C55314

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. C55314

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 937 Linden ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Bent Banks~~ - Pearl Banks

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: N
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-31-97

8. AGE: Years 49 | Months 11 | Days 19 | If less than one day hr. min.

9. Birthplace Bowie Maryland (Town, county, and state)
10. Usual Occupation Janitor
11. Industry or business

FATHER
12. Name Jacob D. Banks
13. Birthplace Carolina Co. Va.

MOTHER
14. Maiden Name Mildred J. Payne
15. Birthplace King George Co.

16 (a) Informant Wilhetta B. Jackson
(b) Address 436 N. Jonathan St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-22-47 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Frederick Avenue

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Ave.

19 (a) SEP 22 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 Sept. 1947, at 7.50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 18 Sept 1947 to 19..., and that I last saw him alive on 18 Sept. 1947

Immediate cause of death	Duration
Cardiac failure	
Due to Coronary occlusion	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank J. Brady M. D.
Address Md. Gen. Hosp. Date signed 9-18-47

VS 150

X

G55315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V/31a

Registered No. G55315

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
Baltimore City Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3022 Poplar Terrace.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME JOHN H. SAUM

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War #1	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Louise J. Saum (nee Lewis) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31, 1885

8. AGE: Years	Months	Days	If less than one day
62	0	18	.....hr. .....min.

9. Birthplace Front Royal, Va.
(Town, county, and state)
10. Usual Occupation Inspector
11. Industry or business Government

FATHER
12. Name John Saum
13. Birthplace Unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Lula J. Saum wife
(b) Address 3022 Poplar Terrace

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/23/47 (month) (day) (year)
(c) Cemetery or crematory Arlington National Cem.
Location Arlington, Va.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 22 1947 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19, 1947, at 4.45 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion
Secondary to arteriosclerosis
Due to Acute Congestive edema of lungs.
Other Conditions Arteriosclerotic heart disease - sclerosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 9-20-47

VS 181

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G55316 JL - 112726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH. 13B

Registered No. G55316

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1707 Jefferson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Woodall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Florence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 6, 1902

8. AGE: Years 45 | Months 1 | Days 12 | If less than one day ... hr. ... min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name George Woodall
13. Birthplace Va.

MOTHER
14. Maiden Name Martha Johnson
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 22 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Balto Co, Md.

18 (a) Funeral director Robert E Wilkerson
(b) Address 1345 N. Eldorry Ave

19 (a) SEP 22 1947 (Date rec'd by registrar) (b) Huntingtown, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18 1947, at 6.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 4 1947, to Sept. 18 1947, and that I last saw h im alive on Sept. 18 1947.

	Duration
Immediate cause of death: Toxemia	3 wks.
Due to: Tuberculous empyema right	2 mos.
Due to: Bilateral pulmonary tuberculosis, far advanced	6 mos.
Other Conditions: Tuberculous pericarditis	

(Include pregnancy within 3 months of death)

Date of operation 8-23-47

Major findings of operation: Thoracotomy for drainage of empyema

of autopsy: see above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
Where did injury occur? (City or town) (County) (State)
(c) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(d) Means of injury

23. Signature Joseph J Bowen Jr. M. D.
Address Balto City Hosp Date signed 9-18-47

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G55317

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution:
Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3616 Gwynn Oak Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary Agnes Dodd

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widowed.

6 (b) Name of husband or wife William J. Dodd
6 (c) If alive, give age Dead years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1879

8. AGE: Years	Months	Days	If less than one day
68	7	8	10 hr. 10 min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name William Hogan
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elizabeth Coquell
15. Birthplace Balto. Md.

16 (a) Informant Dr. William Dodd
(b) Address Mercy Hospital

17 (a) Burial (b) Date thereof Sept 24 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto Md

18 (a) Funeral director Harry N. Amaroso
(b) Address 420 Ridgewood Ave

19 (Date received by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-21 1947 at 10:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 21, 1947 to Sept. 21 1947 and that I last saw her alive on Sept. 21, 1947

Immediate cause of death: Metastatic Carcinoma to lungs. — Duration: 9 mos.
Due to: Primary Carcinoma of breast (removed Sept 1942) — 3 days!!
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation Sept. 1942
Major findings of operation: Radical Mastectomy
of autopsy: Carcinoma

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Joseph Di Pisa M. D.
Address Mercy Hosp Date signed 9/21/47

X

VS 150

Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55318 B704 37 BALTIMORE CITY HEALTH DEPARTMENT G55318
CERTIFICATE OF DEATH 186a Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1420 E. Monument Street. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DELORES (AUSTIN) ALSTON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 24 1946

8. AGE: Years 1 | Months 8 | Days 21 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Hazell Alston
13. Birthplace S C

MOTHER
14. Maiden Name Ruby Young
15. Birthplace Chesterfield S C

16 (a) Informant Ruby Alston
(b) Address 1420 E Monument St.

17 (a) Burial (b) Date thereof (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Mt Calvary Cem
Location Balto Co Md

18 (a) Funeral director Mrs Robt A Elliott Sr
(b) Address 1129 N Carrollton Ave

19 (a) Sept 22 1947 (b) Huntington Williams
(Date rec'd by registrar)

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19, 1947, at 2.40 P M

21. I certify that I took charge of the remains described above, held an inqs & inq. thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture of Skull & Intracranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-19-47 at 10.30 A. M.
(b) Where did injury occur? 1420 E. Monument St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fell from shed-rear of house

23. Signature Earl L Voss M.D. Medical Examiner
Date signed 9-20-47

G55319 ✓ G55319

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 307 S. Ann St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ferdinand W. Jaworski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Edna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 3 1913

8. AGE: Years	Months	Days	If less than one day
34	7	18	hr. min.

9. Birthplace Buffalo N. Y. (Town, county, and state)

10. Usual Occupation Fisher Body Corp.

11. Industry or business Gen. Motors Corporation

FATHER
12. Name John Jaworski
13. Birthplace Poland

MOTHER
14. Maiden Name Katherine Drzyb
15. Birthplace Poland

16 (a) Informant Mrs Edna Jaworski
(b) Address 307 S. Ann street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sep 25 194 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location Balto City

18 (a) Funeral director John M. Weber
(b) Address 1401 S. Chester Street

18 (c) 22 1947 (b) [illegible] Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 1947 at 3:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-24 1947 to 9-21 1947. and that I last saw him alive on 9-21 1947

Immediate cause of death Respiratory paralysis — Duration 48 hrs

Due to Transection spinal cord 5th. Cervical

Due to Fracture dislocation cervical vertebrae

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9-4-47

Major findings of operation: Transection & degeneration spinal cord.

of autopsy Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 9-24-47 at 6 P.M.
(c) Where did injury occur? New Fairview Beach. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public Place (Specify type of place) While at work? No
(e) Means of injury Diving in shallow water

23. Signature Charles R. MacDonald M. D.

Address 1213 Light St Date signed 9-21-47

Dr. C. J. Gutierrez by Howard A. Mercer M.D.

VS 150

G55320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

G55320 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 156 N. Exeter St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State 150 N Exeter St (b) County
(c) City or town Balto md
(If outside city or corporate limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Thomas Menas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Marcella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ~ 1872

8. AGE: Years 75 | Months 2 | Days 2 | If less than one day ... hr. ... min.

9. Birthplace Greece (Town, county, and state)

10. Usual Occupation

11. Industry or business Maria

FATHER
12. Name Thomas Menas
13. Birthplace Greece

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant George Menas
(b) Address 156 N Exeter

17 (a) Burial (b) Date thereof 9-22-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery (or crematory) Greek Cemetery
Location Windsor Mill Rd.

18 (a) Funeral director Lambros
(b) Address 440 E. North ave

19 (a) Sep 22 1947 (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/19/47 at 2:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/19/47 to 9/19/47 and that I last saw him alive on 9/19/47

Immediate cause of death Coronary Thrombosis

Due to Exhaustion

Due to Myocarditis

Other Conditions Contributory

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration: Day / Unknown

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter T. Gordon

Address Hardman Bldg Date signed 9/22/47

X

Send at once is especially important. Physicians: please write the causes of death clearly and legibly.

G55321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

G55321 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway and Fairmount Av.
(c) Hospital or institution: Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 309 S. Collington Av. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Zamecki

3 (b) If veteran, name war	3 (c) Social Security Account No.
No.	No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White.	Married.

6 (b) Name of husband or wife Anna Zamecki -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 29, 1895

8. AGE: Years	Months	Days	If less than one day
51	9	20	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Retired Policeman.
11. Industry or business

FATHER
12. Name Felix Zamecki -
13. Birthplace Germany.

MOTHER
14. Maiden Name Josephine Rechocka
15. Birthplace Germany -

16 (a) Informant Mrs. Anna Zamecki -
(b) Address 309 S. Collington Av.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-23-47 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus Cem
Location Balto. City

18 (a) Funeral director Wm. L. Fialkowski
(b) Address 2007 Eastern Ave

SEP 22 1947 (Date rec'd by registrar) Huntington-Williams Mort.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 19 1947, at 6:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 27 1947 to Sept. 19 1947. and that I last saw him alive on Sept 19 1947.

	Duration
Immediate cause of death Respiratory failure, due to anoxia due to hematemesis	1 mo.
Due to Leukemia - Cirrhosis	years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Robert Haase M. D.
Address Church Home & Hosp. Date signed 9/19/47

X

Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

G55322

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G55322 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1116 Wood Heights Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1116 Wood Heights Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Alverda Hall

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Howard M. Hall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 5, 1882

8. AGE: Years 65 | Months 5 | Days 16 | If less than one day hr. min.

9. Birthplace Ellicott City Howard Co. Md (Town, county, and state)
10. Usual Occupation Household duties
11. Industry or business Own home

FATHER
12. Name John Wesley Merson
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Elizabeth Libby
15. Birthplace Maryland

16 (a) Informant Howard M. Hall
(b) Address 1116 Wood Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 23 47 (month) (day) (year)
(c) Cemetery or crematory St. Johns Cem
Location Ellicott City, Md

18 (a) Funeral director Easton Long
(b) Address 419 Frederick Ave Catonsville

SEP 22 1947 (Date rec'd by registrar)
(b) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21, 1947 at 5:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3, 1947 to Sept 21 1947 and that I last saw h[er] alive on Sept 20 1947.

Immediate cause of death: Cardiac thrombosis — Duration: 3 days
Due to Senile Degeneration — 6 mos
Due to Cirrhosis of Liver — 6 mos
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Hartman
Address 1 E. Randall St. Date signed 9/22/47

X

G55323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

G55323 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not guess at any item, but if the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Clee & Hampton Linthicum Heights
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond J. Disney

3 (b) If veteran, name war
3 (c) Social Security Account No. 213-14-8757

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Myrtle Disney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/14/98

8. AGE: Years	Months	Days	If less than one day
48	10	20	hr. min.

9. Birthplace Odenton, Md (Town, county, and state)
10. Usual Occupation armored car guard
11. Industry or business Brinks.

FATHER
12. Name Summerfield Disney
13. Birthplace Baltimore

MOTHER
14. Maiden Name Estelle Mullinenix
15. Birthplace Odenton Md

16 (a) Informant Mrs. Raymond J. Disney
(b) Address N. Linthicum, Linthicum Hghts, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 23 1947 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Md

18 (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie, Md.

19 (a) SEP 22 1947 (Date rec'd by registrar) Huntington Willis Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/21 1947 at 2:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 19 1947 to Sept. 21 1947 and that I last saw him alive on Sept. 21 1947.

Immediate cause of death	Duration
Cerebral Hemmorrhage	
Due to Essential Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature N. B. Scott M. D.
Address Mercy Hosp. Date signed 9/21

X

55324

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G55324

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1427 JOHN STREET.
(c) Hospital or institution: NO 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) NO
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town CITY BALTIMORE.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1427 JOHN STREET. (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MISS MARY G TAYLOR.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: SINGLE
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) JUNE 17, 1874
8. AGE: Years 73 | Months 4 | Days 3 4 | If less than one day hr. min.
9. Birthplace BALTIMORE (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name SAMUEL GEORGE TAYLOR
13. Birthplace BALTIMORE

MOTHER
14. Maiden Name SARAH JANE
15. Birthplace BALTIMORE

16 (a) Informant CHAS E HERGET
(b) Address 4310 MARBLE HALL Rd.
17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9 23 47 (month) (day) (year)
(c) Cemetery or crematory FRIENDS BURIAL GROUNDS
Location
18 (a) Funeral director CHAS F EVANS & SON
(b) Address 118 W. MT. ROYAL AVE
19 (a) SEP 22 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH SEPTEMBER 21 1947, at 12.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from JULY 14 1947 to SEPT 21 1947, and that I last saw her alive on SEPT 21 1947.

Immediate cause of death	Duration
CARCINOMIA OF COLON JULY 14	1947.
Due to CHRONIC MYOCARDITIS	1947.
Due to ARTERIOR SCLEROSIS.	1947.
Other Conditions HYPERTENSION. (Include pregnancy within 3 months of death)	

Date of operation NONE. Major findings of operation: NONE
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas F Evans
Address 3013 ST PAUL STREET Date signed SEPT 21 1947.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55325 B-C+ 4-89507

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G55325

159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton + Wilkens Ave.
(c) Hospital or institution:
St. Agnes Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr 23 min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 900 Frederick Ave.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Schoelkopf.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/20/47

8. AGE: Years	Months	Days	If less than one day
			1 hr. 23 min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Herbert Earl Schoelkopf
13. Birthplace Md

MOTHER
14. Maiden Name Clara Elizabeth Luker Mahoney
15. Birthplace Md

16 (a) Informant H. Earl Schoelkopf
(b) Address 900 Frederick Ave, Catonsville 28

17 (a) Burial (b) Date thereof Sept 23-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Baltimore Co. Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) SEP 22 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/21 1947, at 12:01 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. M. Wolfe M. D.
Address St Agnes. Date signed

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓50

Registered No. G55326

Write the causes of death clearly and legibly. Cross out all unnecessary words. Physicians: please write plainly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1707 N. Caroline Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME ABAMA B. MARTIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex f | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. , 1875

8. AGE: Years 72 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation retired schoolteacher

11. Industry or business

FATHER
12. Name Thomas B. Martin
13. Birthplace Va.

MOTHER
14. Maiden Name Lillian G. Pendleton
15. Birthplace Va.

16 (a) Informant Malcolm B. Martin
(b) Address 3136 Virginia Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/47 (month) (day) (year)
(c) Cemetery ~~Greenmount~~ Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director John D. Mitchell & Sons
(b) Address 1900 Eutaw Place

SEP 22 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/20/47 19 , at 5:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Generalized carcinomatosis (primary site, left breast)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D. Medical Examiner.
Date signed

X

G55327 B.C.M. G-89478

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G55327 Registered No. 159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: FRANKLIN
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Middle Rivers (If outside city or town limits, write RURAL and give town)
(d) Street No. 8 Maxwell Rd. (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME BABY GIRL (Carol Jean Brown.) BROWN.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/15/47

8. AGE: Years 0 | Months 0 | Days 2 | If less than one day hr. min.

9. Birthplace BALTO, MD, (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name RICHARD ALBERT BROWN

13. Birthplace Balto County, Md.

MOTHER 14. Maiden Name Marguerite CRAWMER

15. Birthplace Owings Mills Md

16 (a) Informant Franklin Square Hosp. Records

(b) Address —

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 9/22/47 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Balto. Co. Md.

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

19 (a) SEP 22 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/20 1947, at 7:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/15 1947 to 9/20 1947, and that I last saw him alive on 9/19 1947.

Immediate cause of death	Duration
ATELECTASIS Congenital.	
Due to	
Due to	
Other Conditions: Premature Infant. (Include pregnancy within 3 months of death)	

Date of operation: —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Ceva Wakwell.
Address Stadtlein Sq. Hosp. Date signed 9/22/47 M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item to be answered. Information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G55328 — BALTIMORE CITY HEALTH DEPARTMENT — G55328

CERTIFICATE OF DEATH 46B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument S.E. + Rutland Ave
(c) Hospital or institution: Sinai Hospital of Balto.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4604 Park Hts Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** Joseph Myers (Joseph A. Meyers.)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mrs. Susan Myers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1872

8. AGE: Years 74 | Months 9 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Shirt Cutter,

11. Industry or business Shirt Manufacturing,

FATHER — 12. Name John Meyers,

13. Birthplace Germany,

MOTHER — 14. Maiden Name Pauline Klier,

15. Birthplace Germany,

16 (a) Informant Sinai Hosp. Records.

(b) Address

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 9/23/47 (month) (day) (year)

(c) Cemetery or crematory Cathedral Cem.

Location Balto. City.

18 (a) Funeral director LeVernon Lemmon.

(b) Address 4611 Park Heights Ave.

19 (a) 1947 (b) Registered Huntington Williams M.D. Registrar

150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1947 at 10:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1947 to Sept 19 1947, and that I last saw him alive on Sept 19 1947.

Immediate cause of death	Duration
Cardiorespiratory failure	
Due to Exanition + cachexia	
Due to Carcinoma of Stomach	
Other Conditions Gangrene rt. foot	

(Include pregnancy within 3 months of death)

Date of operation 7-3-47

Major findings of operation: Carcinoma of stomach involving lesser 1/3 of stom.

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bernard L Colen M. D.

Address Sinai Hosp, Balto, Md Date signed 9-19-47

X

G55329

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G55329

PLEASE WRITE PLAINLY, with unfading ink. Every item must be answered. Use the word "none" where it is applicable. Do not use ditto marks. Be sure to state the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3361 Chestnut Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Widower

6 (b) Name of husband or wife deceased

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 18 Dec 1866

8. AGE: Years	Months	Days	If less than one day
80	11	3	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Edward Walker
13. Birthplace Maryland

MOTHER
14. Maiden Name Lucy Nelson
15. Birthplace Maryland

16 (a) Informant Grace Edrington
(b) Address 3361 Chestnut Ave, Balt.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 24 47 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampden

18 (a) Funeral director Ahearn & Donovan
(b) Address 3615-17 Chestnut Ave.

19 (a) 22 [illegible] (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 Sept 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 18 July 1947 to Sept 19 47 and that I last saw him alive on 21 Sept 19 47.

Immediate cause of death	Duration
Arterio Sclerotic Heart disease - nephro-sclerosis	
Due to generalized atherio-sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Vincent A. Lacace M. D.
Address Franklin Square Hospital Date signed 21 Sept 1947

X

55330

18251 BC# 688827 20-4

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 655330

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address .....

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25

(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County .....

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1004 Shellbank, Rd. (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME Baby-boy Redd

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Col.	

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 9-12-47

8. AGE: Years	Months	Days	If less than one day
		5-4	..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER — 12. Name Joseph Redd

13. Birthplace ?

MOTHER — 14. Maiden Name Christine Leslie

15. Birthplace Md.

16 (a) Informant .....

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (month) (day) (year)

(c) Cemetery or crematory .....

Johns Hopkins Medical Schoo SEP 17 1947

18 (a) Funeral director Commissioner of Health

(b) Address .....

19 (a) SEP 22 1947 (Date received by registrar) Huntington Williams M.D. (Registrar)

VS 150 - 3-48 A

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept-16 1947 at 4 20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-12- 1947 to 9-16- 1947, and that I last saw him alive on 9-16- 1947.

Immediate cause of death CARDIO-VASCULAR COLLAPSE

Due to PREMATURITY

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? ..... (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)

(e) Means of injury .....

23. Signature W. A. Spencer M.D.

Address Johns Hopkins Hospital Date signed 9/16/47 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

55331

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G55331
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 601 North Broadway
(c) Hospital or institution:
The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1914 Aisquith Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Baby Girl Flintall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name David Flintall
13. Birthplace North Carolina

MOTHER
14. Maiden Name Arline Bryant
15. Birthplace Virginia

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Loc Johns Hopkins Medical Schoo SEP 17 1947

18 (a) Funeral director Commissioner of Health ....
(b) Address

19 SEP 22 1947 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 12th 19 47, at 8.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 11th 47, to Sept. 12th 47 and that I last saw her alive on Sept. 12th 47.

Immediate cause of death	Duration
Cranial Hemorrhage	
Basilar of Brain	
Due to Atelectasis by	
Due to Lateral	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B.C. Williams, M.D.
Address Johns Hopkins Hospital Date signed 9-12-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

Registered No. G55332

write the cause of death clearly and legibly. Correct age if apparently improper. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1226 Matthews Street
(c) Hospital or institution: 5-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1226 Matthews Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HAROLD BRACY

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/12/47

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 19 1947

18 (a) Funeral director. Commissioner of Health
(b) Address

1947 SEP 22 1947 Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 14, 1947 at 6:15 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Atelectasis neonatorum

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Ramming, Jr. M.D.
Medical Examiner.
Date signed 15 Sept 1947

55333 O.C. 2-89710

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G55333 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway + Fairmont
(c) Hospital or institution: Church Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 731 S Wolfe Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby boy (B) Brown.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/14/47

8. AGE: Years 0 | Months 0 | Days 4 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Baby.

11. Industry or business

FATHER
12. Name Walter Brown
13. Birthplace

MOTHER
14. Maiden Name Ruth Steward
15. Birthplace Virginia

16 (a) Informant Mrs Ruth Brown
(b) Address 731 S Wolfe Ave.

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 18 1947

18 (a) Funeral director Commissioner of Health
(b) Address
SEP 22 1947 (a) (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/17 1947, at 4:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/14 1947 to 9/17 1947 and that I last saw him alive on 9/17 1947.

Immediate cause of death	Duration
Cessation of Respiration	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Gross + Substitutional Prematurity

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. J. Fisher M. D.
Address Church Home Hosp. Date signed 9-16-47

X

55334

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 1316

Registered No. G55334

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 53 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2½ mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State W.Va. (b) County
(c) City or town St. Marys
(If outside city or town limits, write RURAL and give town)
(d) Street No. 506 Barron Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Denzil Burton Newland

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	236-14-4253

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife ---
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28, 1909

8. AGE: Years	Months	Days	If less than one day
38	7	24	hr. min.

9. Birthplace W.Va. (St. Marys)
(Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business Merchant Seaman

FATHER
12. Name Howard R. Newland
13. Birthplace Ohio

MOTHER
14. Maiden Name Sarah Coutter
15. Birthplace W.Va.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Removal (b) Date thereof 9-22-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location St. Marys, West Virginia

18 (a) Funeral director Angela A. Farley
(b) Address Baltimore & Fayette Sts.

19 (a) SEP 22 1947 (b) Huntington, W. Va.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21 1947 at 8:40P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 19 1947, to Sept. 21 1947, and that I last saw him alive on Sept. 21 1947.

Immediate cause of death	Duration
Chronic glomerular nephritis	6 mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stuart M. Sessoms
Stuart M. Sessoms, Asst. Surgeon M. D.
Address US Marine Hospital Date signed 9/22/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V S. 150

X

G55335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G55335

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Levindale Home
(c) Hospital or institution:
Belvedere & Greengaping ave
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2200 Allendale Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLARA Eva BERG

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Widow

6 (b) Name of husband or wife. Late Hyman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Austria
(Town, county, and state)

10. Usual Occupation
11. Industry or business None

FATHER
12. Name Samuel Rosenthal
13. Birthplace Austria

MOTHER
14. Maiden Name Mollie ?
15. Birthplace Austria

16 (a) Informant Mrs Annette Sykes
(b) Address 5013 Sunset Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 23/47 (month) (day) (year)
(c) Cemetery or crematory New York City
Location New York

18 (a) Funeral director Sol Levinson & Bro
(b) Address 1124-26 W Baltimore

19 (a) SEP 22 1947 (Date rec'd by registrar) (b) Huntingtown Williams, MD (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-22 1947, at 10a M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-28 1946, to 9-22 1947 and that I last saw h[e] alive on 9-22 1947.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to	
Due to	
Other Conditions Diabetes	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Wajd M. D.
Address Levindale Home Date signed 9-22-47

VS 150

94a

G55336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164E

G55336
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 124- S. Ellwood Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARIE BACHMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Geo. H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 24-1875

8. AGE: Years	Months	Days	If less than one day
71	11	26	hr. min.

9. Birthplace Frankford Ger. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ? Sturm
13. Birthplace Germany

MOTHER
14. Maiden Name Dorothea Unrow
15. Birthplace Germany

16 (a) Informant Geo. H. Bachman
(b) Address 124 S. Ellwood.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 23-47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director John J. Hagan
(b) Address 3000 E. Balto. St.

SEP 22 1947

19 (a) (Date rec'd by registrar) (b) Huntington-Williams, Md. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20, 1947, at 6.50 A M

21. I certify that I took charge of the remains described above, held an insp. & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull &
Intracranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-20-47 4.30 a. M.
(b) Where did injury occur? 124 S. Ellwood Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Jumped from 2nd story window

23. Signature Earl L. Kay M.D. Medical Examiner.
Date signed 9-20-47

X

BALTIMORE CITY HEALTH DEPARTMENT

G55337 **CERTIFICATE OF DEATH** 1937 G55337 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey St.
(c) Hospital or institution: Good Samaritan Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 27 N Carey St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ignatius J Kircher

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20. 1882

8. AGE: Years 65 | Months 3 | Days 25 29 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace "

MOTHER 14. Maiden Name "
15. Birthplace "

16 (a) Informant Anna Kirchner
(b) Address Garland Court

17 (a) Burial (b) Date thereof 9-23-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Baltimore Md

18 (a) Funeral director Milton Gaddis
(b) Address 1219 Pine St.

19 (a) SEP 1947 (b) Geo Williams, Jr. Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/19/47, at 11:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 10 1947, to Sept 19 1947, and that I last saw him alive on Sept. 18 1947.

Immediate cause of death: Cardiac Resp. Failure — Duration: Immediate

Due to Congestive Heart Failure — Duration:

Due to Hypertension — Duration:

Other Conditions Senility. — Duration:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles Tammaccelo M. D.
Address 910 W. Lombard Date signed 9-20 1947.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

VS 150

X 1947.

G55338 / BALTIMORE CITY HEALTH DEPARTMENT G55338
Registered No.

CERTIFICATE OF DEATH 92 c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1619 N. Calvert St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1619 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel N. Wagner

3 (b) If veteran, name war W. W. #1

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) ~~Single~~, married, ~~widowed or divorced~~ Married

6 (b) Name of ~~husband or wife~~ Lelia May Wagner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 25 - 1897

8. AGE: Years 50 | Months 2 | Days 26 | If less than one day hr. min.

9. Birthplace Penna
(Town, county, and state)

10. Usual Occupation Fireman (Locomotive)

11. Industry or business B & O R. R.

FATHER 12. Name John Wagner

13. Birthplace Pa.

MOTHER 14. Maiden Name Hannah Morikonk

15. Birthplace Pa.

16 (a) Informant Mrs. Lelia M. Wagner

(b) Address 1619 N. Calvert St

17 (a) Burial (b) Date thereof 9/24/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Lorraine

Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc

(b) Address 217 St. Paul St.

19 (a) SEP 2 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21st 1947, at 1.50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/15 1947, to 9/21 1947, and that I last saw ~~him~~ alive on 9/20 1947.

Immediate cause of death Acute dilatation of heart — Duration 2 days

Due to Rheumatic endocarditis in childhood —

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry D McCarty M.D.

Address 37 W Preston St Date signed 9/22/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

G55339 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2902 Bauernwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2902 Bauernwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes Slattery

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, ~~married~~, widowed, or ~~divorced~~
Female	White	Widowed

6 (b) Name of husband ~~of~~ Bartholomew Slattery
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 11th 1870

8. AGE: Years	Months	Days	If less than one day
76	10	10	hr. min.

9. Birthplace Ireland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business at Home

FATHER
12. Name John Darcy
13. Birthplace Ireland

MOTHER
14. Maiden Name Eliza Johnson
15. Birthplace Ireland

16 (a) Informant Mrs. Margaret Willem
(b) Address 2902 Bauernwood ave

17 (a) Burial (b) Date thereof 9/24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St.

19 (a) 9 1947 (b) Function from Hillen Funeral Home
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21st 1947, at 7.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1947, to 9/21/47, and that I last saw h. alive on Sept 21 1947.

Immediate cause of death	Duration
Myocardial Insufficiency	2 yrs
Due to Aged Senility	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Fred J. Zimmerman M.D.
Address 9558 Harford Rd Date signed 9/22/47

VS 150

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G55340

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G55340 (93) Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1704 N. Wolfe St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 N. Wolfe St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl G. Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband Walter L. Anderson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 31st 1884

8. AGE: Years 63 | Months 7 | Days 1920 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Former wife

11. Industry or business Own Home

FATHER
12. Name William Walstrum
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Annie Cadle
15. Birthplace Balto. Md.

16 (a) Informant Samuel W. Smith
(b) Address 2866 Lake Ave

17 (a) Burial (b) Date thereof 9/23/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Balto. Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) 1947 (b) Huntington Williams Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 20 1947 at 1:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/7 1940 to 9/20 1947 and that I last saw her alive on 9/19 1947

	Duration
Immediate cause of death: Coronary Thrombosis & Infarction	3 days
Due to: Hypertensive Cardio Vascular Disease	7 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Karl Grossman M. D.

Address 1212 N. Patterson Park Ave Date signed 9/22/47

X

Please write the causes of death clearly and legibly. Physicians: please write so that your signature is especially important.

Dr. Nathaniel Beck St. Paul + 23rd St BE 9016-Zn 6663

G55341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G55341

write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 726 E. North Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 726 E. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie C. Sorter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, ~~married~~, widowed, or divorced: Widowed

6 (b) Name of husband or wife: George W. Sorter

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 24th 1856

8. AGE: Years	Months	Days	If less than one day
90	10	26	hr. min.

9. Birthplace Penna.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name Jesse T. McCaffrey
13. Birthplace Penna.

MOTHER
14. Maiden Name Mary E. Downar
15. Birthplace Ohio

16 (a) Informant Mrs. E. Comer Smith
(b) Address 4501 Penhurst Ave

17 (a) Burial (b) Date thereof 9/24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

SEP 22 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 20th 1947 at 8 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1930 to Sept 20 1947 and that I last saw h. alive on Sept 20 1947

Immediate cause of death	Duration
Coronary thrombosis	Immediate
Due to Chr. Arteriosclerosis	Indefinite
Due to	
Other Conditions Subacute Bronchitis	1 wk.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathaniel M Beck M. D.
Address 100 E. 23rd St Date signed Sept 22 1947

G55342 BCH D89280 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH 161a G55342 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 hr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 519 Mosher St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Deborah Ann Gilmore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex fe | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1947

8. AGE: Years | Months | Days | If less than one day 1 hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Earl Gilmore
13. Birthplace Balto., Md.

MOTHER 14. Maiden Name Beatrice Deborah Scott
15. Birthplace Balto., Md.

16 (a) Informant Beatrice Gilmore mother
(b) Address 519 Gilmore St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 9-22-47 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location Baltimore County

18 (a) Funeral director J. L. Preston Lynchburg
(b) Address 519 Mosher St

19 (a) SEP 22 1947 (Registrar) (b) Huntington Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20 1947 at 7:12 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 20 1947, to Sept. 20 1947, and that I last saw her alive on Sept. 20 1947

Immediate cause of death	Duration
Congenital atelectasis of lungs, bilateral	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James D. Carr M. D.
Address 515 Mosher St Date signed 9-22-47

X

55343

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 94a

G55343
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland ✓
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: The Seton Institute
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-4-27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pennsylvania (b) County
(c) City or town Greensburg (If outside city or town limits, write RURAL and give town)
(d) Street No. Seton Hill College (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sister M. Adele McCullough

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March, 1865

8. AGE: Years	Months	Days	If less than one day
80 82	6		hr. min.

9. Birthplace Gallitzin, Pennsylvania (Town, county, and state)
10. Usual Occupation Religious Teacher
11. Industry or business

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name unknown
15. Birthplace "

16 (a) Informant The Seton Institute
(b) Address 6420 Reisterstown Road, Baltimore, Md.

17 (a) Removal (Burial, cremation, or removal) Date thereof 9-22-47 (month) (day) (year)
(c) Cemetery or crematory
Location Greensburg Penna

18 (a) Funeral director George A. Farley
(b) Address Guilford Ave. Baltimore

SEP 22 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION 1947

20. DATE OF DEATH 9/22 1947, at 12:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death	Duration
Coronary Occlusion	3 days
Due to Arteriosclerosis.	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daniel P. Alyea M. D.
Address 336 Fredericks (State address)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry of information in spaces provided for the causes of death clearly and legibly. correct age is especially important. Physicians: please write the

55344 BC# 689192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157c

Registered No. G55344

Write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Ashburton St
(c) Hospital or institution: West Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 - 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto 29-Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 3120 Stafford St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Parker

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/13/47

8. AGE: Years	Months	Days	If less than one day
			hr. 20 min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Elwood Levin Parker
13. Birthplace Balto 29-Md

MOTHER
14. Maiden Name Margie McGrow
15. Birthplace Montreal, Canada

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 16 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) Date received by local registrar SEP 22 1947 (b) Signature of local registrar Hunting for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/13/47 19 , at 7:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6:45 P.M. 9/13 19 47 to 7:55 P.M. 9/13 19 47 and that I last saw HIM alive on 9/13 19 47.

Immediate cause of death	Duration
Anencephalus Monster	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Florence S. Greenbaum M. D.
Address W. Balt. Gen. Hosp. Date signed 9/13/47

G55345 BC# B-89086 BALTIMORE CITY HEALTH DEPARTMENT / 157E G55345

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 138 Oakdale Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Burkow

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9, 1947

8. AGE: Years | Months | Days | If less than one day: hr. 37 min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name H. Clifford Burkow Jr
13. Birthplace

MOTHER
14. Maiden Name Marjory Robinson
15. Birthplace New York.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

(Date rec'd by registrar) Registrar

University Medical School SEP 16 1947
Commissioner of Health
SEP 22 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11 1947 at 10:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 11 1947 to Sept 11 1947 and that I last saw h[illegible] alive on 10:30 Sept 11 47.

Immediate cause of death: Congenital Heart Anomaly

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Theresa Burkow M.D.
Address Maryland Gen Hosp Date signed 9/12

VS 150

5346

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

168

Registered No. C55346

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16-5
(c) Hospital or institution Provident Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Boa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 Moreland Avenue (stock)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick WALKER

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 11 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 23 1947 (Date received by registrar) (Signature) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31, 1947, at 1 35 M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull
Intracranial hemorrhage
Contusion of brain

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-31-47 at ? M.
(b) Where did injury occur? 1400 Moreland Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Stock While at work? No
(d) Means of injury Struck on head with fence stock.

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 9/2/47

X

55347 D. Wagner — BALTIMORE CITY HEALTH DEPARTMENT — G55347

about 10/28/47

CERTIFICATE OF DEATH 36

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 24 - 3

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1001 Williamson Street. (If rural give location) William
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia B. BOHNER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Lewis K. Bohner — 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/29/1918

8. AGE: Years	Months	Days	If less than one day
28	10	23	hr. min.

9. Birthplace Gutman Pa (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER: 12. Name John Markovich
13. Birthplace Poland

MOTHER: 14. Maiden Name
15. Birthplace Poland

16 (a) Informant Mr L. K. Bohner
(b) Address 1001 Williamson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Ritchie Highway

18 (a) Funeral director J. J. Zahler Sons
(b) Address 1318 Light St

19 (c) SEP 23 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21, 1947, at 9.20 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Bulbar Poliomyelitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mallios M.D. Medical Examiner.
Date signed 9-22-47

X

C55348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. C55348

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 708 N. Mount St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 708 N. Mount St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eleanor (Elenora Bell)

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 5/31/1879
8. AGE: Years 68 Months 4 3 Days 19 20 If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Florence Andrews
(b) Address 922 N. Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-24-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Maryland

18 (a) Funeral director William A. Johnson
(b) Address 916 Penna. Ave.

19 (a) SEP 23 1947 (Date rec'd by registrar) (b) Interment Lot Williams Mt. Auburn Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20 1947, at 9P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 6 1947, to Sept 20 1947 and that I last saw h[illegible] alive on 9-20 1947.

Immediate cause of death: Cerebral Hemorrhage — Duration: 2 hrs

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature B. F. Hatcher M. D.
Address 1775 Park Date signed 9/22/47

55349 [Gruley] BALTIMORE CITY HEALTH DEPARTMENT ✓ G55349
CERTIFICATE OF DEATH 83a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 219 N. Pearl St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-2
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 219 N. Pearl St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Gruley (Stewart)

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-5-1897

8. AGE: Years 49 | Months 9 10 | Days 13 | If less than one day hr. min.

9. Birthplace Marion, S. C. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant William Stewart
(b) Address 219 N. Pearl St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-23-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto, Maryland

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna Ave.

SEP 22 1947 Huntington Williams M.D.
(Filed) (Signature of registrar)

V$ 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18, 1947 at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 6 1947 to Sept 18 1947
and that I last saw h alive on 19
Immediate cause of death Cerebral hemorrhage
Duration 2 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [signature] M.D.
Address 219 N. Pearl St. Date signed 9-22-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

55350

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. 55350

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution: Church Home + Hospital Inc
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 922 N. Washington St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Rosenstein

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-03-5006

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 15, 1884

8. AGE: Years	Months	Days	If less than one day
62	11	23	hr. min.

9. Birthplace New York (town, county, and state)
10. Usual Occupation Cigar Maker
11. Industry or business Cigar Industry

FATHER
12. Name Harris Rosenstein
13. Birthplace Russia

MOTHER
14. Maiden Name Bessie ?
15. Birthplace Russia

16 (a) Informant Patient.
(b) Address Dead.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-23-47 (month) (day) (year)
(c) Cemetery or crematory Mount Friendship
Location

18 (a) Funeral director Jack Levin Inc.
(b) Address 2100 Eutaw Place
(c) Date received by registrar SEP 23 1947 Huntington Williams Mortuary

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/22/47 1947, at 7:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/16 1947 to 9/22 1947 and that I last saw h.IM. alive on 9/16 1947

Immediate cause of death Carcinomatosis

Due to Origin unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9/16/47

Major findings of operation: Generalized carcinomatosis of abdomen

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. Wineburg

Address Church Home + Hosp. Date signed M. 9/22/47 D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

55351 314811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 655351

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 N. Gay, St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Harry Wuntzberger (Wurtzburger)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10 1873

8. AGE: Years 73 | Months 11 | Days 12 | If less than one day ..... hr. ..... min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Trav. Salesman
11. Industry or business

FATHER
12. Name Harry Wurtzberger
13. Birthplace Germany ?

MOTHER
14. Maiden Name Janet Haas
15. Birthplace Germany ?

16 (a) Informant Mrs. Harry Wuntzberger
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (b) Date thereof 9/25/47 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director David Sonnheim's Son
(b) Address 1902 Eastern Place

19 (a) SEP 23 1947 (Date rec'd by registrar) (b) Registered by Wilson, M.D.

VS 150

MEDICAL CERTIFICATE

20. DATE OF DEATH Sept. 22 1947, at 1 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-21- 1947 to 9-22 1947, and that I last saw h/m alive on 9-22- 1947

Immediate cause of death: Coronary Occlusion — Duration: 3

Due to: Coronary arteriosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard C. Olan M. D.
Address Johns Hopkins Hosp Date signed 9/23/47

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G55852 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 4-
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 730 E. Pratt Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter C. Baker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, ~~married, widowed, or divorced~~: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 4th 1889

8. AGE: Years 58 | Months 1 | Days 18 | If less than one day hr. min.

9. Birthplace Prince George Co. Md.
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business Handyman

FATHER 12. Name Thomas L. Baker

13. Birthplace Md.

MOTHER 14. Maiden Name Mary R. Benson

15. Birthplace Md

16 (a) Informant Mrs Emma C. Nicklas

(b) Address 3821 Pleasant Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25/47 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location A. A. Co. Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St Paul st

19 (a) SEP 23 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 22, 1947, at 6 45 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary artery disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner

Date signed 9-22-47

VS 181

5353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 82a

Registered No. G55353

Print clearly in ink. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 612 N. Gilmor St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 612 N. Gilmor St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Thomas Spencer Robertson. Jr.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Frances Robertson,
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 4, 1912

8. AGE: Years: 35 | Months: 7 | Days: 17 | If less than one day: hr. min.

9. Birthplace Winnsboro, S.C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Thomas Robertson
13. Birthplace Winnsboro, S.C.

MOTHER
14. Maiden Name Lamar
15. Birthplace Winnsboro, S.C.

16 (a) Informant Mrs. Frances Robertson
(b) Address 612 N. Gilmor St

17 (a) Shipped (b) Date thereof 9-22-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Winnsboro S.C.

18 (a) Funeral director Mrs Katie Rufus Williams
(b) Address 322 N. Schroeder St.

19 SEP 22 1947 (b) Waiting for Williams Mill
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/21/47 19 , at 8-4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/18/47 19 , to 9/21 19 47
and that I last saw h alive on 19

Immediate cause of death
Subarachnoid Hemorrhage
Due to Spontaneous

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
3 hr

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. W. Nicklin M.D.

Address 612 N. Gilmor Date signed 9/22/47

G55354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

G55354 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2007 Frederick Ave.
(c) Hospital or institution:
20-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2007 Frederick ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Muench

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Widower

6 (b) Name of husband or wife late Mary A. Braun

6 (c) If alive, give age 87 years

7. Birth date of deceased (mo., day, yr.) Aug 18, (1870)

8. AGE: Years	Months	Days	If less than one day
76 (77)	1	3	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Daniel Muench
13. Birthplace Germany

MOTHER
14. Maiden Name —
15. Birthplace Germany

16 (a) Informant Robert Muench
(b) Address 2007 Frederick Ave

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 9. 47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Rd

18 (a) Funeral director Harry H. Wisler
(b) Address 4101 Edmondson Ave

19 (a) Date received by registrar SEP 22 1947 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12 Sept 1947 to 20 Sept 1947 and that I last saw him alive on 20 Sept 1947.

Immediate cause of death Cerebral hemorrhage — Duration

Due to arteriosclerosis

Due to senility

Other Conditions Paralysis right arm and right leg.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H H Bayless M. D.
Address 1600 Wetherd Ave Date signed 22 Sept 47

PLEASE WRITE CLEARLY, using ink. Give cause of death. Do not use terms like heart disease, cancer, etc., without stating the cause of death clearly and legibly. Physicians: please write the correct age in especially important.

VS 150

5355

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G55355 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1229 N. Spring St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10-1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1229 N Spring St (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Franklin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 16-1880

8. AGE: Years 67 | Months 5 | Days 3 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth Lewis
15. Birthplace Md

16 (a) Informant Leroy Franklin
(b) Address 1229 N. Spring St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-24-47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Co

18 (a) Funeral director Rayner Sanders
(b) Address 1113 E. Preston St

SEP 23 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 5th 1947 to Sept 19 1947, and that I last saw h[illegible] alive on 9/19 1947.

Immediate cause of death Bronchopneumonia — Duration 2 days
Due to
Due to Hypertension
Other Conditions Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert L. Lefevre M.D.
Address 822 N. Bond St Date signed 9/23/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

55356

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G55356 Registered No.

please write the causes of death clearly and legibly. Physicians: please see that every item is correctly filled in. Be sure that the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 641 W. Conway St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 641 W Conway St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace A. A. Co. Md (Town, county, and state)

10. Usual Occupation House Work

11. Industry or business

FATHER
12. Name Samuel Hammond
13. Birthplace A. A. Co. Md

MOTHER
14. Maiden Name Emma Fisher
15. Birthplace A. A. Co. Md

16 (a) Informant Emma Giles
(b) Address 641 W. Conway St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 23, 47 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Brooklyn Md

18 (a) Funeral director Chas O. Wilson
(b) Address 1000 Eastern Ave

19 (a) SEP 23 1947 (Date rec'd by registrar) (b) Irvington-Williams Mfr

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20 1947 at 6 55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1947 to Sept. 20 1947 and that I last saw her alive on Sept 20 1947.

Immediate cause of death	Duration
Bronchopneumonia	6 days
Due to Senile Debility	—
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John H. Gaines
Address 507 W. Hamburg St Date signed 9/22/47 M.D.

X

G55357

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

Registered No. G55357

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2552 West Lombard St.
(c) Hospital or institution: ********** 2D
(d) Length of stay in hospital or inst. (yrs., mos., or days) ****
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2552 West Lombard Street (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME LISETHE E. MOHR

3 (b) If veteran, name war **********

3 (c) Social Security Account No. **********

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: George Mohr

6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr.) Aug. 8, 1889

8. AGE: Years 58 | Months 1 | Days 13 | If less than one day ********** hr. min.

9. Birthplace: Baltimore Maryland (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: At Home.

FATHER
12. Name: George C. Eichner
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Mary A. Uhl
15. Birthplace: Maryland

16 (a) Informant: Miss Frieda Eichner
(b) Address: 2552 West Lombard Street

17 (a) CREMATION (Burial, cremation, or removal) (b) Date thereof 23 Sept. 47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore Maryland

18 (a) Funeral director: F. B. WIPPERT & SON
(b) Address: 1300 EUTAW PLACE.....17

19 (a) SEP 3 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 21 st. 1947 1:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1946 to Sept 21 1947. and that I last saw her alive on Sept 20 1947.

Immediate cause of death: Carcinoma of uterus (Cause)

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation Apr 1946

Major findings of operation: Carcinoma uterus - metastases thru

of autopsy: [illegible]

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Otis Jones M.D.

Address 2818 St. Paul Street Signed 9-7-47 M. D.

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G55858

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1334 W. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1334 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Alberta Conway

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 27, 1874

8. AGE: Years	Months	Days	If less than one day
72	11	25	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Charles H. Conway
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary Hiss
15. Birthplace Germany

16 (a) Informant Mrs. Harold Goodwin niece
(b) Address 3012 N. Calvert St.

17 (a) Burial (b) Date thereof 9/24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address 947 Balto., Md.

19 (a) SEP 23 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 22 1947, at 4:30 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 1941, to Sept 22 1947, and that I last saw h alive on Sept 22 1947.

Immediate cause of death

Carcinoma of Liver — Duration 1 yr.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl Pass, M.D.
Address 4001 Wilkens Ave Date signed 9-23-47

VS 150

PLEASE WRITE PLAINLY, with pen and ink. Physicians: please write the cause of death clearly and legibly. Exact age is especially important.

Q55359

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1243

Registered No. Q55359

Please write the causes of death clearly and legibly. Physicians: please write age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2005 Cecil Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2005 CECIL AVENUE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH ANNA BORGFELDT

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	WIDOW

6 (b) Name of husband or wife Emmanuel Borgfeldt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1871

8. AGE: Years	Months	Days	If less than one day
76	3	29	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Herman Banke
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mr. Alvin E. Borgfeldt
(b) Address 1225 Circle Drive - 27

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-25-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) SEP 22 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 22 1947, at 10.45A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 21 1946 to Sept 22 1947, and that I last saw her alive on Sept 18 1947.

Immediate cause of death	Duration
Pituitary	
× Partial cystadenoma	
Cirrhosis	Ans.
Due to secondary to Chr.	Months
Nephritis	years.
Due to	2
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Sept 16
Major findings of operation: Adherent gallbladder & liver cirrhosis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Hyde M. D.
Address 1150 E North Ave Date signed 9/23/47

×

V S 150

G55360

JL - 113438

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. G55360

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 26-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 604 S. Oldham St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Theresa Barth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Frank
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Nov. ~~23~~ ~~1876~~ 1874

8. AGE: Years	Months	Days	If less than one day
72 (70)	10	13	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Carew ? (Beckmuth) Volkmuth
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Schmidt
15. Birthplace Germany

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-26-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Lilly & Zeller Inc.
(b) Address 403 S. Wolfe St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

SEP 23 1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22 19 47 at 4 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 30 19 47 to Sept. 22 19 47 and that I last saw h or alive on Sept. 22 19 47

Immediate cause of death	Duration
Bronchopneumonia	
Due to Arteriosclerotic Cardio-vascular disease	
Due to	
Other Conditions Cirrhosis of liver.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: As above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Tucker J. M. D.
Address Balto. City Hosp. Date signed 23 Sept 47

X

G55361

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G55361

Please write the causes of death clearly and legibly. Physicians: please write; correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1301 Park Ave.
(c) Hospital or institution:
27-14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4203 Somerset Place
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Savannah B. Butt

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Edward H. Butt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1871

8. AGE: Years	Months	Days	If less than one day
76 73	7 5		hr. min.

9. Birthplace Ga.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Thomas Barett
13. Birthplace Ga.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Shirley C. Morgan
(b) Address 4203 Somerset Road

17 (a) Burial (b) Date thereof 9/25/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery
Location Augusta, Ga.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1930 Eutaw Place

19 (a) 9-23-1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22 1947, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1935 to Sept 22 1947, and that I last saw her alive on Sept 22 1947

Immediate cause of death	Duration
Cerebral Hemorrhage	4 days
Arterio. sclerosis	Instant
Due to Hypertension	
Due to Myocarditis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W H Neady M. D.
Address 1403 Park Ave. Date signed 9/23/47

VS 150

X

M. D. R. 1268-9

5362 **HEALTH DEPARTMENT—CITY OF BALTIMORE** G55362

CERTIFICATE OF DEATH 937

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 5611 Belle Vista St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Charles Bennett Jones

(a) Residence: No. 5611 Belle Vista St., 27-4 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M	W	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Clorinda -

6. DATE OF BIRTH (month, day, year) Dec. 12-1866

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	9	11	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired Police

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Balto - Md.

FATHER

13. NAME Bennett Jones

14. BIRTHPLACE (city or town) (State or country) Md.

MOTHER

15. MAIDEN NAME Mary E.

16. BIRTHPLACE (city or town) (State or country) Md.

17. INFORMANT Mildred M. Dingman

(Address) 5611 Belle Vista Ave

18. BURIAL, CREMATION, OR REMOVAL

Place Baltimore Date 9/27/47

19. UNDERTAKER Leonard J. Luck

(Address) 5305 Harford Ca. 14-

20. Filed SEP 23 1947 Theodore A. Williams, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Sept 23, 1947

22. I HEREBY CERTIFY, That I attended deceased from July 1, 1947 to Sept 23, 1947

I last saw him alive on Sept 23, 1947 Death is said to have occurred on the date stated above, at 3:40A m.

The principal cause of death and related causes of importance were as follows:

	Interval between onset and death
Coronary Thrombosis	9-23-47
Other contributory causes of importance: Arteriosclerotic Cardio Vascular disease	1 yr.

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury , 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) Geo. M. Dennis Gardner M. D.

(Address) Balto 6. Md

G55363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G55363

TURNley. 13B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Aberdeen Md
CARSEN (If outside city or town limits, write RURAL and give town)
(d) Street No. RUN Carsin Run
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Zanetta Turnley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~or wife~~ Clyde Turnley

6 (c) If alive, give age 25 years

7. Birth date of deceased (mo., day, yr.) June 2 1921

8. AGE: Years 26 | Months 3 | Days 20 | If less than one day ... hr. ... min.

9. Birthplace Aberdeen Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name T. Asbury Driggs

13. Birthplace Aberdeen Md

MOTHER 14. Maiden Name Martha Dobbin

15. Birthplace Baltimore

16 (a) Informant Mrs. Clyde Turnley

(b) Address Aberdeen Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 25 1947 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location Aberdeen Md

18 (a) Funeral director Henry Fleming Sons

(b) Address Aberdeen Md

19 (a) SEP 23 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22 1947 at 7 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-12 1947 to 9-22 1947 and that I last saw her alive on 9-22 1947

Immediate cause of death	Duration
Tuberculous meningitis with Subarachnoid Block	
Due to Pulmonary Tuberculosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Asbury D. Pache

Address University Hosp. Date signed 9/23

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55364

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 128

Registered No. G55364

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2253 W. Baltimore St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2253 W. Baltimore Street (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Thomas

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: John E. Thomas
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.): April 5, 1874

8. AGE: Years 73 | Months 5 | Days 16 | If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: Home

FATHER
12. Name: Peter Reidt
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Germany

16 (a) Informant: Mrs. John Satterley
(b) Address: 2253 W. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-24-47 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet
Location: Baltimore, Maryland

18 (a) Funeral director: Geo. L. Schwab
(b) Address: 210 E. Frederick Avenue

19 (a) SEP 23 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21, 1947, at 7:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/18 1947 to 9/21 1947. and that I last saw h[illegible] alive on 9/20 1947

Immediate cause of death	Duration
Acute Pancreatitis	1 week
Due to	
Due to	
Other Conditions Chronic Cholecystitis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Chas. W. Cahn M. D.
Address: 2145 W Balto St Date signed: 9-22-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every question must be answered. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

55365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 055365

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 225 East North Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 - 5
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 225 East North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY FLORENCE BYRNE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Sydney Byrne
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
77 79			hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John Kehoe
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Cleary
15. Birthplace Ireland

16 (a) Informant Mr. John Kehoe
(b) Address 316 East North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location City

18 (a) Funeral director WIEDEFELD AND SON
(b) Address GREENMOUNT AVE & 22ND

19 (a) REC'D 22 1947 (Date received by registrar) (b) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-21-47 19 , at 10 05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1947 to Sept 21 1947 and that I last saw her alive on Sept 21 1947

Immediate cause of death — Duration

Carcinoma of transverse Colon — Unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ferd A. Pires M. D.
Address 245 S. Broadway Date signed 9/22/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55366

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G55366 R

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 2912 Bauernwood Rd

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 27yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2912 Bauernwood Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William D Keller

3 (b) If veteran, name war

3 (c) Social Security Account No 213-03-7070

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Edna B Heller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 29 1866

8. AGE: Years 71 | Months | Days | If less than one day hr. min.

9. Birthplace Bradley Lee Pa
(Town, county, and state)

10. Usual Occupation Asst Buyer

11. Industry or business J Nauds & Co

FATHER 12. Name Wm J Heller

13. Birthplace Pa

MOTHER 14. Maiden Name Dont Know

15. Birthplace Pa

16 (a) Informant Mrs J. Heller

(b) Address Box 298. RFD 9

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 26 (month) (day) (year)

(c) Cemetery or crematory Lorraine Park

Location Rural

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2008 Arlington Av

19 (a) SEP 23 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23 1947, at 8 AM

21. I certify that I took charge of the remains described above, held an Aut & Insp thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic - Cardio - Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature William G Hoffheck M.D.
Medical Examiner.

Date signed Sept 23, 1947

G55367

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 485

Registered No. G55367

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1312 Harlem Ave,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1312 Harlem Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Moore.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Augustus Moore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-21-1892

8. AGE: Years 55 | Months - | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Wesley Johnson
13. Birthplace Westminster Md.

MOTHER
14. Maiden Name Louisa Stephens
15. Birthplace West Riviy Md.

16 (a) Informant Mrs. James Johnson
(b) Address 1809 W. Fairvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-23-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Mt Wash

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder Street

19 (a) SEP 23 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-17-1947 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-11-1947 to 9-19-1947 and that I last saw her alive on 9-18-1947

Immediate cause of death	Duration
General Paralysis	14 days
Due to	
Due to	over
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury Burn from dumper.

23. Signature [illegible]

Address [illegible] Date signed 9-23-47

X

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

Birth Cert # 46-87652

5369

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G55369

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore Co.
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 968 Frankstown Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Ann Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31 1947

8. AGE: Years	Months	Days	If less than one day hr. min.
		17 days	

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Meredith Marcellus Smith
13. Birthplace Frederick, Md.

MOTHER
14. Maiden Name Beatty
15. Birthplace Frederick Md.

16 (a) Informant Hospital and
(b) Address Birth Certificate

17 (a) (Burial, cremation, or removal) (b) Date there (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School SEP 19 1947

18 (a) Funeral director Commissioner of Health

(b) Address

(c) [illegible] Huntington Williams, M.D.

SEP 23 1947
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-17- 1947, at 5 55 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-31 1947, to 9-17 1947, and that I last saw her alive on 9-17 1947.

Immediate cause of death Prematurity — Duration 17 days

Due to

Due to

Other Conditions Bronchopneumonia — 1 day

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter B. Sanger, M. D.
Address Bon Secours Hospital Date signed 9/17/47

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correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55370

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G55370 Registered No. 1782

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 601 Cathedral St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Stanislaus Guyda

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12 1906

8. AGE: Years	Months	Days	If less than one day
41	XXX	10	hr. min.

9. Birthplace Oil City Penn.
(Town, county, and state)

10. Usual Occupation Governament Clerk

11. Industry or business Social Security

FATHER
12. Name Sam John Guyda
13. Birthplace Poland

MOTHER
14. Maiden Name Victoria M. Okalck
15. Birthplace Poland

16 (a) Informant Francis Casimar Guyda
(b) Address 712-19th St. N.W. Washington D.C.

17 (a) Removal (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery XXXXXXXX Calvary
Location Venango County Pa. Oil City Pa.

18 (a) Funeral director Frank Della Vecchia
(b) Address 52 N. Morley St.

19 (a) SEP 23 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH September 22 1947, at 3.50 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to Carbon Monoxide

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-22-47 at 3:15 P M (11/2)
(b) Where did injury occur? 601 Cathedral St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? Not remaining
(d) Means of injury. Body caught fire while

23. Signature Earl K. Bryan M.D.
Medical Examiner.
Date signed 9-23-47

55271 Allen 2-36

CWK-100745

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G55271

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue 26-12
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Years 5 Mos. 1- 5-
(e) Length of stay in Baltimore (yrs., mos., or days) [illegible] Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Homelane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
William Augustus Cheney

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 215-03-1232

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. DIVORCED.

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 8-1886

8. AGE: Years 61 | Months | Days 13 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph (D)
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Layman (D)
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9 24 47 (month) (day) (year)
(c) Cemetery or crematory CEDAR HILL
Location RITCHIE HIGHWAY

18 (a) Funeral director JOHN F DENNY, INC.
(b) Address 715 LIGHT ST.

19 (a) 9-24-1947 (Date received by Registrar) (b) Huntington Williams, M.D.

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21 1947, at 3:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 20 1946, to Sept. 21 1947, and that I last saw h. im alive on Sept. 21 1947.

Immediate cause of death: Congestive Heart Failure — Duration
Due to: Arteriosclerotic Heart Disease — Duration
Due to: Coronary Arteriosclerosis — Duration
Other Conditions — Duration
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Coronary Sclerosis
of autopsy: Cardiac Enlargement

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. K. Scarbrough M. D.
Address Balto. City Hosp. Date signed 9-21-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No. 655372

5372

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

5373

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45a

G55373 Registered No.

write the causes of death clearly and legibly. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 803 E. Chase St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 803 E. Chase St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John G. Hebler

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11. 1874

8. AGE: Years 72 | Months 10 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Retired Cloth Cutter

11. Industry or business

FATHER
12. Name Gustav Hebler
13. Birthplace Washington D.C.

MOTHER
14. Maiden Name Magdelina Polster
15. Birthplace Germany

16 (a) Informant Mrs. Henry A. Hebler
(b) Address 803 E. Chase St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 26, 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location 4430 Beloh Rd

18 (a) Funeral director Edgar W. Conkling & Son
(b) Address 929 E. Eager St.

19 (a) 9 24 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23 1947 at 12:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/2 1946 to 9/22 1947. and that I last saw h. alive on 9/22 1947.

Immediate cause of death	Duration
Epithelioma of Lip + Cheek	
Metastasis to brain	
Due to Ca. Myocarditis.	
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)
Date of operation Nov 9 '46
Major findings of operation: Carcinoma of cheek
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. L. Horstein M. D.
Address 733 Asquith St Date signed 9/23/47

V S 150

G55374

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. G55374

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2007 Fleet Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis Henry Wilczynski

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1943

8. AGE: Years	Months	Days	If less than one day
4	1	25	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Joseph Wilczynski
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Frances Drzmala
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Frances Wilczynski
(b) Address 2007 Fleet St.

17 (a) Burial (b) Date thereof 9-25-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George R. Weber
(b) Address 705 S. Linn St.

19 (a) SEP 24 1947 (b) Katherine Williams
(Date rec'd by registrar) Registrar

Vs 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 22 1947, at 7:45 P.M.

21. I ~~certify that I~~ took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Abdominal hemorrhage
Ruptured spleen
Ruptured diaphragm
~~Due to~~ Ruptured intestine
Peritonitis.
~~Other Conditions~~ Edema of lungs.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 2/3
(a) Date of injury 9-22-47 at 11:30 A.M.
(b) Where did injury occur? Fleet & Washington St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? no
(d) Means of injury Ped. struck by truck

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 9-23-47

655375

BALTIMORE CITY HEALTH DEPARTMENT

TN. 109285 **CERTIFICATE OF DEATH** 13B Registered No. 655375

please write the causes of death clearly and legibly. Physicians: please

correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6- & 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 403 S. Cornwell St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond Bialecki

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20th 1929

8. AGE: Years	Months	Days	If less than one day
18	1	3	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Bialecki
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Marza
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-26-47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ St Stanislaus
Location Baltimore Md

18 (a) Funeral director George A Weber
(b) Address 705 S. Linn st

19 (a) 9-24-1947 (Date received by registrar) (b) Registrar [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23/1947 19 47, at 5.00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 19th 19 47, to Sept. 23 19 47, and that I last saw h er alive on Sept 23/ 19 47.

Immediate cause of death	Duration
Hemoptysis	100 da
Due to Endobronchial Tuberculosis	9 mo
Due to Tuberculosis of lungs for advanced	9 mo
Other Conditions Otitis media bilateral, chronic	3 wks

(Include pregnancy within 3 months of death)

Date of operation 7-24-47
Major findings of operation: Intraplural pneumonolysis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Bowen Jr M. D.
Address Balto City Hosp Date signed 9-23-47

55376

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G55376 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1725 WILMINGTON AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 20YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1725 WILMINGTON AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE DILLMAN

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-12-3609 C.

4. Sex M | 5. Color or race WHT | 6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife MATILDA

6 (c) If alive, give age 87 years

7. Birth date of deceased (mo., day, yr.) AUG 19 [illegible]

8. AGE: Years 69 | Months 1 | Days 23 | If less than one day: hr. min.

9. Birthplace GERMANY (Town, county, and state)

10. Usual Occupation CHEF

11. Industry or business BELVEDERE HOTEL.

FATHER
12. Name GEO DILLMAN
13. Birthplace GERMANY

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace GERMANY

16 (a) Informant MATILDA DILLMAN
(b) Address 1725 WILMINGTON AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-25-47 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK.
Location FREDERICK AVE

18 (a) Funeral director GEO LEIMBACH
(b) Address 525 N LYNDHURST ST

SEP 24 1947 (Date received by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 22 1947, at 2 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/15 1947 to 9/22 1947, and that I last saw him alive on 9/22 1947.

Immediate cause of death Cerebral Thrombosis — Duration 34 days

Due to Arteriosclerotic C-V-D & Auricular Fibrillation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature P. Chrisp Rowberg M.D.
Address 2411 Washington Blvd Date signed 9/23/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered No. 55377

55377

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 40 S. Fremont Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 40 S Fremont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter S. Wautekunas

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b). Name of husband or wife: Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years: 68 | Months | Days | If less than one day: hr. min.

9. Birthplace: Lith. (Town, county, and state)

10. Usual Occupation: Tailor

11. Industry or business

FATHER
12. Name: Wautekunas
13. Birthplace: Lith.

MOTHER
14. Maiden Name: ?
15. Birthplace: Lith

16 (a) Informant: Anna Wautekunas
(b) Address: 40 S. Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 25-47 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer Cem
Location: Belair Rd

18 (a) Funeral director: Joseph Kasenskas
(b) Address: 607 Washington Blvd

19 (a) 9-24-1947 (b) Signature of registrar: Huntington Williams M.D.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22, 1947, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 20, 1947 to Sept. 22, 1947, and that I last saw him alive on Sept. 21, 1947.

Immediate cause of death: Cerebral Hemorrhage — Duration: 2 days.
Due to: Cerebral Arteriosclerosis — 10 years.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: [illegible]
Address: Federal Hill Date signed 9/23/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

55378

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 55378

Please write the causes of death clearly and legibly. Physicians: please write age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 911 W. Fayette St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 911 W. Fayette St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE M. SCOTT

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	219-16-6324

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/28/1914

8. AGE: Years	Months	Days	If less than one day
33	3	22	hr. min.

9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation Brick Mason
11. Industry or business

FATHER
12. Name Benj. Scott
13. Birthplace N.C.

MOTHER
14. Maiden Name Lucy Ann Scott
15. Birthplace N.C.

16 (a) Informant Janie Alston
(b) Address 911 W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave

SEP 24 1947 Huntington Williams M.D.
(Date received) (Registrar) Registrar

VS 150 ... A

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/20/47 19 , at 4:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-18 19 to 9-20 19 47 and that I last saw h alive on 9-20 19 47

Immediate cause of death	Duration
Acute Nephritis	7 Wks
Due to Intoxication	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address 861 Hart Pl Date signed 9-23-47

G55379

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G55379 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given as carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 days
(e) Length of stay in Baltimore (yrs., mos., or days) 31 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6301 Blackburn Ct.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Marian Stevenson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Raymond S. Stevenson

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Jan 27, 1897

8. AGE: Years 50 | Months 8 | Days 28 | If less than one day 16 hr. min.

9. Birthplace Wilmington, Delaware
(Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name Matthew J. Haley
13. Birthplace Ireland.

MOTHER
14. Maiden Name Margaret Lynch
15. Birthplace Ireland

16 (a) Informant Raymond S. Stevenson
(b) Address 6301 Blackburn Ct.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9.26.47 (month, day, year)
(c) Cemetery or crematory Woodland Park
Location Gaylor Ave.

18 (a) Funeral director John A. McGann
(b) Address 4267 Greenmount Ave.

19 (a) FEB 24 1947 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22, 1947, at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 18, 1947 to Sept. 22 1947, and that I last saw h[illegible] alive on Sept. 22, 1947

Immediate cause of death	Duration
Cerebrovascular accident (hemorrhage)	35 days
Due to Hypertensive cardiovascular disease	10 mos.?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph LiPuma M. D.
Address Mercy Hosp. Date signed 9-22-47

X

55380

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

G55380 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3221 Esther Place
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6
(e) Length of stay in Baltimore (yrs., mos., or days) 69 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3221 Esther Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Andrews

3 (b) If veteran, name war O (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Widowed

6 (b) Name of husband or wife Geo. J. Andrews
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
68	1	3	hr. min.

9. Birthplace Balt. Maryland
(Town, county, and State)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Burnes Burhorat
13. Birthplace Maryland

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs Mary M. Hellman
(b) Address 3221 Esther Place

17 (a) Burial (b) Date thereof 9 / 25 / 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Dunmanway Rd

18 (a) Funeral director John G. Moran
(b) Address 200 E. Baltimore St

19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 22 1947 at 3 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 18 1947 to Sept 22 1947 and that I last saw her alive on Sept 22 1947

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Noelie A Andersen M. D.
Address 3001 Shannon Drive Date signed 9/24/47

Balto 13 Md

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

55381

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G55381 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5304 EUGENE AVENUE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5304 Eugene Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY GROVER HOFFERBERTH

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 215-07-4203

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Catherine A. (Storch)

6 (c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): Mar. 21, 1885

8. AGE: Years 62 | Months 6 | Days 1 | If less than one day ____ hr. ____ min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Marine Machinish

11. Industry or business: Beth. St. Co. Key Hwy

FATHER
12. Name: John Hofferberth
13. Birthplace: Germany

MOTHER
14. Maiden Name: Margaret Krause
15. Birthplace: Maryland

16 (a) Informant: Mrs. Catherine A. Hofferberth
(b) Address: 5304 Eugene Avenue -8

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-25-47 (month) (day) (year)
(c) Cemetery or crematory: Parkwood Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC
(b) Address: NORTH AVE. & BROADWAY

19 SEP 24 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION A. M

20. DATE OF DEATH September 22 1947 at 10.50 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1942 to Sept 22 1947
and that I last saw him alive on Sept. 20 1947

Immediate cause of death: Ch. Myocarditis — Duration: 5 Years
Due to: Ch. Hypertension
Due to: Arterio Sclerosis
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: J S Harding
Address: 3805 Belair Rd Date signed: 9/22/47 M. D.

X

55382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No. 65382

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 402 Fremont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LeRoy Strickland

3 (b) If veteran, name war No | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/13/Age

8. AGE: Years 47 | Months 3 | Days 8 | If less than one day hr. min.

9. Birthplace Albemarle Co, N.Y
(Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER 12. Name unobtainable
13. Birthplace

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Florence Strickland
(b) Address 5067 Fremont Ave

17 (a) Burial (b) Date thereof 9/24/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Wm. H. Kelson
(b) Address 1363 Pennsylvania Ave

19 (a) SEP 24 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/21 1947, at 10:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/20/47 to 9/21/47 and that I last saw h[illegible] alive on 9/21 1947.

Immediate cause of death: Congestive Heart Failure — Duration 9 hrs
Due to: Mitral Stenosis — Duration ?
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Kelson
Address 752 Conge St Date signed 9/25/47

PLEASE WRITE PLAINLY; Physicians: please write the correct age is especially important.

55383 BALTIMORE CITY HEALTH DEPARTMENT G55383

CERTIFICATE OF DEATH 186a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Church Home Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6d.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1621 E. Lanvale
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) FULL NAME Mr. William T. Joynes

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary A. Joynes
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 4, 1854

8. AGE: Years 93 | Months 4 | Days 19 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland (Balto.)
(town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John T. Joynes
13. Birthplace Virginia (Accomac Co.)

MOTHER
14. Maiden Name Sarah Tunnell
15. Birthplace Va.

16 (a) Informant Mrs. Mabel Regester
(b) Address 1621 E. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/26/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) ..... (b) ..... Registrar
(Date rec'd by registrar)

VS 1[illegible]

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23 1947, at 7:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 18 1947, to Sept 23 1947, and that I last saw him alive on Sept. 22 1947.

	Duration
Immediate cause of death: Unknown. Coronary Sclerosis with myocardial fibrosis. Terminal Bronchopneumonia	
Due to: Fracture L. Femur	6 days
Due to: ?	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None.
Major findings of operation:
of autopsy: Coronary Sclerosis etc.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 8/6
(a) Accident, suicide, or homicide: Accident
(b) Date of occurrence: Sept. 17 Afternoon
(c) Where did injury occur? Baltimore (City or town) Md. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury: Fall to floor over rug

23. Signature: Henry W. Wilson M. D.
Address: Church Home Hosp. Date signed: 9-23-47

Howard D. Mallonee, M.D.

G55384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G55384 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1324 Eutaw Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1324 Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HERBERT F. O'DELL

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife A. Mabel O'Dell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 20, 1875

8. AGE: Years	Months	Days	If less than one day
72	6	3	hr. min.

9. Birthplace Baltimore Co., Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Edward C. O'Dell
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden Name Emily Haviland
15. Birthplace Balto. Co., Md.

16 (a) Informant Mrs. A. Mabel O'Dell
(b) Address 1324 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Cem.
Location Randallstown, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 24 1947 (Date rec'd by registrar) (b) [illegible] Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23, 1947, at 1:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 1947 to 23 Sept. 1947 and that I last saw h alive on 23 Sept. 1947.

Immediate cause of death	Duration
Acute pulmonary edema	1 hour
Due to Arteriosclerotic heart disease	
Due to	
Other Conditions Generalized arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John F. Hagenbuch Jr.
Address 120 E. Eutaw Place Date signed 23 Sept 47

55385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. 55385

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert St. ~~5706 Loch Raven Blvd.~~
(c) Hospital or institution: Union Memorial Hospy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ——
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5706 Loch Raven Blvd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Wilfrid Laurier Preston

3 (b) If veteran, name war: WORLD WARS #1 & #2

3 (c) Social Security Account No. 212-16-2338

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ulva Agnes M. Preston

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) April 30, 1897

8. AGE: Years 50 | Months 4 | Days 28 | If less than one day ____ hr. ____ min.

9. Birthplace Toronto, Canada
(Town, county, and state)

10. Usual Occupation Vocational advisor

11. Industry or business Veterans Administration

FATHER
12. Name Robt. B. A. Preston
13. Birthplace Canada

MOTHER
14. Maiden Name Retha Ray
15. Birthplace Canada

16 (a) Informant Mrs. Agnes Preston
(b) Address 5706 Loch Raven Blvd

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/25/47 (month) (day) (year)
(c) Cemetery or crematory Arlington National Cem.
Location Arlington, Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) ____ (Date rec'd by Registrar) (b) ____ Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23 1947, at 8:09 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/25 1947, to 9/23 1947, and that I last saw him alive on 9/23 1947.

Immediate cause of death: Carcinoma in liver with ascites — Duration: 6 months

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation Sept 6 1947

Major findings of operation: ascites (Crosby button placed)

of autopsy: Carcinoma in liver & ascites

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. Wade Alford M. D.
Address Union Memorial Hosp Date signed 9-23-47

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

S-55386

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. (S-55386)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 207 N. Montford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 wks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 207 N. Montford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie M. Ennis
3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Domestic
6 (b) Name of husband or wife Isaac
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1872
8. AGE: Years 75 | Months | Days | If less than one day hr. min.
9. Birthplace Md (Town, county and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER 12. Name Harman Thomas
13. Birthplace Md

MOTHER 14. Maiden Name ?
15. Birthplace Md

16 (a) Informant Charles Ennis
(b) Address 207 N. Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) SEP 25 47
(c) Cemetery or crematory Mt Calvary Cemetery
Location Balto Co Md

18 (a) Funeral director Robert F Williams
(b) Address 45 45 [illegible] Baltimore, Md

19 (a) SEP 24 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 20 1947 at 1:30 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 1937 to Sept 20 1947.
and that I last saw h alive on Sept 11 1947.

Immediate cause of death	Duration
Myocardial Insufficiency	2 wks
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
Signature Silvia D. Fry M. D.
Address 2302 Eutaw Place Date signed 9/23/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every question must be answered. Be certain that information about the cause of death is correct and complete. Physicians: please write the correct age is especially important.

VS 150

55387

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. 55387

Cite the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 211 S. Wolfe St.
(c) Hospital or institution:
NONE
(d) Length of stay in hospital or inst. (yrs., mos., or days) –
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 211 S. Wolfe St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country – – –

3 (a) FULL NAME George F. Dorfler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Bertha
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-9-1887

8. AGE: Years	Months	Days	If less than one day
60	4	12	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Mortician
11. Industry or business Lilly & Zeiler Inc.

FATHER
12. Name Michael Dorfler
13. Birthplace Germany

MOTHER
14. Maiden Name Mary A. Sterner
15. Birthplace Maryland

16 (a) Informant Bertha Dorfler - Wife
(b) Address 211 S. Wolfe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-25-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belmir Rd. - Balto.

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. Wolfe St.

19 SEP 24 1947 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21 1947, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 11, 1947 to Sept. 21, 1947, and that I last saw him alive on Sept. 16, 1947.

Immediate cause of death Coronary Thrombosis Myocardial failure — Duration about 2 mos.
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Nathan H. Spritz, M. D.
Address 1810 Eutaw Pl. Date signed 9/23/47

V S 150

G55388 BALTIMORE CITY HEALTH DEPARTMENT G55388
CERTIFICATE OF DEATH 93E Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) Boa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 905 Carey Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Bostick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1893.

8. AGE: Years 54 | Months 3 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Dennis Bostick
13. Birthplace Frederick, Md.

MOTHER
14. Maiden Name Esther Booze
15. Birthplace Frederick, Md.

16 (a) Informant Bertha Gray
(b) Address 1708 Presbury St.

17 (a) Burial (b) Date thereof 9-25-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 32 N. Stockton St.
Huntington Williams, Md.

SEP 24 1947
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 40

20. DATE OF DEATH September 21, 1947, at 6 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Due to Acute Congestive Heart Failure

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl A. Royer M.D.
Medical Examiner
Date signed 9-22-47

VS 151

X

G55389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

(G55389) Registered No. 61

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Jewish Hosp.
(c) Hospital or institution: Dr
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7½ h
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto Parkville (If outside city or town limits, write RURAL and give town)
(d) Street No. 2801 Hillcrest (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian M. Kutlik

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mr. CHARLES J. Kutlik

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) 4-9-78

8. AGE: Years 69 Months 5 Days 15 If less than one day ____ hr. ____ min.

9. Birthplace Balto - Md. (Town, county, and state)

10. Usual Occupation H W

11. Industry or business

FATHER
12. Name Henry Guan
13. Birthplace ? Tenn.

MOTHER
14. Maiden Name Shirley Scoggins
15. Birthplace Balto

16 (a) Informant Husband
(b) Address 2801 Hillcrest

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/47 (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road
Huntington Williams, M.D.

19 47 (Date rec'd by registrar) (b) Registrar

24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every question must be answered. Where there is any doubt as to correct age in especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-24 1947, at 1 1/2 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-23 1947 to 9-24 1947 and that I last saw h.e. alive on 9-24 1947.

Immediate cause of death: Pneumonic Coma — Duration 24 h

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm Hunt M.D.

Address Mercy Date signed 9-27-47

VS 150

X

G55390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G55390 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry of the causes of death clearly and legibly. correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 833 Hollins St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 50

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 833 Hollins St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME KASIMIER STANIS

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M.
5. Color or race W
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Costancia
6 (c) If alive, give age 65 years
7. Birth date of deceased (mo., day, yr.) 1875
8. AGE: Years 72 | Months | Days | If less than one day hr. min.
9. Birthplace Lithuania (Town, county, and state)
10. Usual Occupation Tailor Retired
11. Industry or business

FATHER
12. Name
13. Birthplace Lithuania

MOTHER
14. Maiden Name
15. Birthplace Lithuania

16 (a) Informant Costancia Stanis
(b) Address 833 Hollins St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-25-47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.
18 (a) Funeral director Chas. W. Lackman
(b) Address 703 McHenry St.
19 (a) (Date rec'd by Registrar) (b) Registrar

SEP 24 1947 Huntington Woods, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-22-47 19 , at 11:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-1-47 19 , to 9-22-47 19 , and that I last saw him alive on 9-22-47 19 .

	Duration
Immediate cause of death Pulmonary edema	
Due to Arteriosclerotic Heart disease	2-3 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 642 Wash. Blvd Date signed 9-24-47 M. D.

G55391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G55391

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3337- W. Belvedere Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3337- W. Belvedere Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME ALLEN BENSON ALBRIGHT

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 213-10-2751

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1889

8. AGE: Years 57 | Months 11 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore Co., Md
(Town, county, and state)

10. Usual Occupation Operator
11. Industry or business Bulk Transit Co

FATHER
12. Name Lyrup Albright
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Sealtha Fishpaw
15. Birthplace Maryland

16 (a) Informant Mrs. Ellen M. Smyth (Sister)
(b) Address 4024 Falls Rd

17 (a) Burial (b) Date thereof Sept 25 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Jensons
Location Baltimore Co., Md

18 (a) Funeral director Unger Funeral Home
(b) Address 3631 Falls Rd Harrisburg for Baltimore, Md.

SEP 24 1947 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23, 1947, at 7 a. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary artery Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Unger M.D.
Medical Examiner
Date signed 9-23-47

VS 191

G55392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 73a

G55392 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 618 N. Hilton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 618 N. Hilton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cecelia F. Mules

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	widow

6 (b) Name of husband or wife Late David Frank

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1875

8. AGE: Years	Months	Days	If less than one day
72	1	10	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business

FATHER
12. Name Henry Mehrling
13. Birthplace Germany

MOTHER
14. Maiden Name Mary E. Adams
15. Birthplace Md.

16 (a) Informant Mrs. Mehrling F. Mules
(b) Address 3004 Virginia Ave

17 (a) Burial (b) Date thereof 9/25/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Wittle
(b) Address 4101 Edmondson ave

19 (a) (b)
(Date rec'd by registrar) Huntington Williams, M.D.

SEP 24 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/22/47, 19, at 6:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947 to 9/22 1947 and that I last saw h[er] alive on 9/22 1947.

Immediate cause of death	Duration
Pernicious Anemia	10 yrs ±
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Tyre E. Powell M. D.
Address 3629 E. Monument Date signed 9/23/47

X

W. Va. 655393

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 655393

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave.
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County Cabell
(c) City or town Huntington
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1463 Edwards St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond R. Withers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife La Veta Withers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24 1911

8. AGE: Years	Months	Days	If less than one day
36	4	0	hr. min.

9. Birthplace Ben Lomond, W. Va.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Robert C. Withers
13. Birthplace Apple Grove, W. Va.

MOTHER
14. Maiden Name Grace McNeill
15. Birthplace Mercury Bottom, W. Va.

16 (a) Informant La Veta B. Withers
(b) Address 1463 Edwards St. Huntington W. Va

17 (a) Removal (b) Date thereof 9-24-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Huntington, W. Va.
Location Huntington, W. Va.

18 (a) Funeral director Wm. Cook Inc.
(b) Address 1217 4th Ave.

19 (a) (b)
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/24 1947, at 9:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/29 1947 to 9/24 1947, and that I last saw h.i.m. alive on 9/23 1947.

Immediate cause of death	Duration
Uremia	
Due to Malignant Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy HCVD - Arteriolar sclerosis -

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman M. Marcus M.D.
Address 1 Mon Hill Date signed 9/24/47

Baltimore MD

102

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

655394
TN. 113933

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1947

Registered No. 655394

Please write the causes of death clearly and legibly. Physicians: please see that age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 818 Bergundy St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Gary

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 82? - Jan. 22, 1865

8. AGE: Years	Months	Days	If less than one day
82	8	2	hr. min.

9. Birthplace ? Delaware
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name James H. Gary
13. Birthplace Delaware

MOTHER
14. Maiden Name Mary Virginia Price
15. Birthplace Kent Co. Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/26/47 (month) (day) (year)
(c) Cemetery or crematory Still Pond
Location Still Pond Kent Co. Md.

18 (a) Funeral director Maria V. Williams
(b) Address Chestertown, Md

19 SEP 25 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION P M

20. DATE OF DEATH Sept 24th 1947 19 , at 1.50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19th 19 47 to Sept 24 19 47 and that I last saw h im alive on Sept 24th 19 47

Immediate cause of death	Duration
Bronchopneumonia	
Due to Cerebral Vascular Accident	
Due to Hypertensive Cardiovascular Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wallace H. Winters M. D.
Address Balt City Hosp. Date signed 9/25/47

X

G55395 LW13832

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. G55395

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 25-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3547 6th. St. - Brooklyn (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Washington Dailey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of ~~husband or~~ wife Vennie Dailey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15- 1881

8. AGE: Years 66 | Months 2 | Days 8 | If less than one day ... hr. ... min.

9. Birthplace Md. (Balto. Co.) (Town, county, and state)

10. Usual Occupation Handyman

11. Industry or business U. S. Coast Guard

FATHER 12. Name John W. Dailey
13. Birthplace Ireland

MOTHER 14. Maiden Name Sarah E. Warfield
15. Birthplace Westminster Md

16 (a) Informant Records - B.C.H.
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/26/47 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) SEP 25 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23- 1947, at 4:13A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 3 1947, to Sept. 23 1947, and that I last saw him alive on Sept. 23 1947.

	Duration
Immediate cause of death: Chronic Myeloid Leukemia	9 months
Due to:	
Due to:	
Other Conditions: Hypertensive Cardio-Vascular Disease (Include pregnancy within 3 months of death)	years

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hosp. Date signed 9-23-47

VS .150

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G55396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓50

G55396 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 W. CAROLINE ST
(c) Hospital or institution: ST JOSEPH'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE-13-MD (If outside city or town limits, write RURAL and give town)
(d) Street No. 1109 N. MILTON AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY KATHERINE RITTER

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) ~~Single, married, widowed, or divorced~~ W

6 (b) Name of husband or wife Joseph J. Ritter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) July 3rd 1876

8. AGE: Years 71 | Months 2 | Days 21 | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business at Home

FATHER 12. Name (Unknown) Murray
13. Birthplace Ireland

MOTHER 14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Augusta Erwin
(b) Address 2224 R. St. S.E. Washington D.C.

17 (a) Burial (b) Date thereof 7/26/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) SEP 25 1947 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/24 1947, at 5 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/18 1947 to 9/27 1947, and that I last saw her alive on 9/24 1947.

Immediate cause of death	Duration
CACHEXIA	
RESPIRATORY FAILURE	
Due to CARCINOMATOSIS	
Due to CARCINOMA OF THE BREAST	
Other Conditions GENERALIZED ARTERIOSCLEROSIS	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy: CA OF BREAST E METASTASIS

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry J. Hamaker M.D.
Address 1 E Jos Hosp. Date signed 9/24/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

55397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1950

G55397 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 N. Dennison St.
(c) Hospital or institution:

15-6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1721 Braddish Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BLANCIE O. O'CONNOR

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife William B. O'Connor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 20, 1893

8. AGE: Years	Months	Days	If less than one day
53	11	2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name - Scheeler
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mr. William O'Connor
(b) Address 1721 Braddish Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25/47 (month) (day) (year)
(c) Cemetery or crematory Baltimore National Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 25 1947 (Date rec'd by Registrar) (b) Thurlington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22, 1947, at 11:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1947, to Sept 22 1947, and that I last saw h— alive on Sept 22 1947.

Immediate cause of death	Duration
Asphyxiation	
Filipillation	
Mitte Condige	
Due to Decompensation	
Due to Entero sclerosis & Rheumatic fever	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.
Address 3093 W North Ave Date signed 9-24-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55398

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G55398 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4103 BELVEDERE AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) 89Y6M12D10

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4103 BELVEDERE AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZA J. MILLER.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race WHT | 6 (a) Single, married, widowed, or divorced WIDOW.

6 (b) Name of husband or wife DEAD.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-2-1858

8. AGE: Years 89 | Months 6 | Days 21 | If less than one day hr. min.

9. Birthplace BALTO MD
(Town, county, and state)

10. Usual Occupation NONE.
11. Industry or business

FATHER
12. Name SEBASTIN KELLY
13. Birthplace NOT KNOWN

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace " "

16 (a) Informant MRS VIOLA KREINER
(b) Address 4103 BELVEDERE AVE

17 (a) BURIAL (b) Date thereof 9-26-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LOUDON PK.
Location FREDK AVE

18 (a) Funeral director GEO LEIMBACH
(b) Address 525 N. LYNDHURST ST.

19 SEP 25 1947 Date filed by Registrar [illegible] for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-23-47, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1947 to 9/23 1947, and that I last saw h[illegible] alive on 9/23 1947.

Immediate cause of death: Arteriosclerotic Cardio-Vascular Renal Disease (old age) — Duration 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph X. [illegible] M.D.

Address 1206 E. Fayette St Date signed 9/24/47

VS 150

C55399

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No. C55399

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3718 Brooklyn Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No 3718 Brooklyn Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Priscella Reed Gabler

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Joseph M.
(c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Oct 15 1866

8. AGE: Years 80 | Months 11 | Days 7 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Joseph Christofer
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs Worthy Mayo
(b) Address 3718 Brooklyn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/47 (month) (day) (year)
(c) Cemetery or crematory Mountain View
Location Harford Co.

18 (a) Funeral director John F Kenny Inc
(b) Address 716 Eight St.

19 SEP 25 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 22 1947 at 7 20 M.

21. I certify that death occurred on the date above stated; that I attended deceased from FEB 16, 1946 to SEPT 22 1947 and that I last saw her alive on SEPT 22 1947

Immediate cause of death HYPOSTATIC PNEUMONIA — Duration 3 DAYS

Due to MITRAL REGURGITATION — UNKNOWN

Due to RHEUMATIC FEVER — UNKNOWN

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James E Peterman

Address 1216 Hanover St Date signed 9/24/47 M. D.

VS 150

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G55100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G55100

Please write the causes of death clearly and legibly. Physicians: please write age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1310 Myrtle Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1310 Myrtle Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES HENRY PAYNE

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	Married

6 (b) Name of ~~husband~~ or wife Bertie Garrett Payne
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25, 1881

8. AGE: Years	Months	Days	If less than one day
66	7	29	hr. min.

9. Birthplace Goochland County, Va. (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Kermit Payne
13. Birthplace Virginia

MOTHER
14. Maiden Name Martha Payne
15. Birthplace Virginia

16 (a) Informant Kermit Payne (Son)
(b) Address 1310 Myrtle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cemetery
Location Baltimore, Md.

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Avenue

19 (a) SEP 25 1947 (Date filed) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24 1947 at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1947 to Sept 24 1947 and that I last saw h alive on Sept 24 1947.

Immediate cause of death

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2 wks

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. D.
Address 801 Madison Ave Date signed 9-26-47

VS 150

655101 BC# 83380

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

655101 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Be sure that the information given in this certificate is correct and complete. Use no abbreviations. Where the exact information is not known, approximate dates should be given if possible. Be sure that the age is correctly stated. Be especially careful to report the correct age in all cases where the deceased is under one year or one day old. Please answer all questions.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2513 Guilford ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 2513 Guilford ave (If rural give location) 3
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Paul Ittner

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	✓

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8, 1947

8. AGE: Years	Months	Days	If less than one day
-	2	15	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation ✓
11. Industry or business

FATHER
12. Name Joseph A. Ittner
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Dorothy C. Miller
15. Birthplace Baltimore, Md

16 (a) Informant Dorothy C. Miller mother
(b) Address 2513 Guilford ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 25/47 (month) (day) (year)
(c) Cemetery or crematory Mew Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Kreyer Funeral Home
(b) Address 1216 S. Carrollton Ave.

19 SEP 25 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23 1947 at 6:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 8 1947, to Sept 23 1947, and that I last saw h/ alive on Sept 19 1947.

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Congenital Heart disease	
Due to Patent inter auricular septum	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward L. Fiegl Jr. M.D.
Address 2 W. Read St Date signed 9/24/47

VS 150

G55402

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓168

G55402 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provd Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 19 W. Hall Street (If rural give location) Hill
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Furman Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1917

8. AGE: Years	Months	Days	If less than one day
30			hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Eugene Williams
13. Birthplace S. C

MOTHER
14. Maiden Name Bessie Boston
15. Birthplace N. C

16 (a) Informant Charles Williams
(b) Address 19 W Hill St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-25-47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location a. a. Co Md

18 (a) Funeral director Isaiah L Brown Sons
(b) Address 108 W Montgomery St

19 (a) SEP 25 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23, 1947, at 11 25 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury 9/22/47 at 11 25 P. M.
(b) Where did injury occur? Hill Street near Hanover Street
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Fists fight

23. Signature Earl E Royer M.D. Medical Examiner.
Date signed

G55103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered No. G55103

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2075 Rockrose Ave
(c) Hospital or institution: Ardleigh Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 - 13
(e) Length of stay in Baltimore (yrs., mos., or days) 69 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4000 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Max Rosenberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Bessie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) M

8. AGE: Years 77 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Russia

MOTHER
14. Maiden Name unknown
15. Birthplace Russia

16 (a) Informant Samuel Rosenberg
(b) Address 3960 Penhurst Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-25-47 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Friendship

18 (a) Funeral director Jack Lewy Inc
(b) Address 216 Ontario Place

19 (a) SEP 25 1947 (Date rec'd by registrar) (b) Huntingtor Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-23- 1947 at 5P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 18 1947 to Sept 23 1947 and that I last saw h alive on Sept 23 1947

Immediate cause of death Cardiac Failure — Duration 4-5 day
a pulmonary Edema
Due to Right sided Hemiplegia — 3 wks
Due to Arteriosclerosis — 3 or 4 yrs
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert H. Kolmen
Address 3700 Park Heights Date signed Sept 25 1947 D.

X

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

G55104

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G55104

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2316 E. Baltimore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and name town)
(d) Street No. 2016 E. Balto St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Karfel Friedland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Minnie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Baruch
13. Birthplace Russia

MOTHER
14. Maiden Name Minnie
15. Birthplace Russia

16 (a) Informant Minnie Friedland
(b) Address 2316 E Balto St

17 (a) Burial (b) Date thereof 9-25-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Adas Israel
Location No Point + German Hall Rd

18 (a) Funeral director Jack Lewis Inc
(b) Address 3100 Eutaw Place

19 SEP 25 1947 (b) Huntington Williams M.D.
(Date filed by Registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-23- 1947, at 4:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/20, 1947 to 9/23, 1947 and that I last saw h[illegible] alive on 9/23, 1947

Immediate cause of death	Duration
Chronic nephritis	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. G. Snooman M.D.
Address 1109 N. Calvert Date signed 9/24/47

X

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G55405

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G55405

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 45yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 7527 Quantico Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel Mehlman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Lena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (City, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name Salman

13. Birthplace Russia

MOTHER 14. Maiden Name Unknown

15. Birthplace Russia

16 (a) Informant Mrs Sadie Koltzman

(b) Address 7527 Quantico Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-25-47 (month) (day) (year)

(c) Cemetery or crematory Hebrew Young Men's Location Montefiore Mem Road

18 (a) Funeral director Jack Lewis Inc

(b) Address 2 E Eutaw Place

19 SEP 25 1947 (Date Rec'd by Reg. Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/23/1947, at 9:48 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/27 1947 to 9/23 1947 and that I last saw h I m alive on 9/23/1947.

Immediate cause of death Coronary Thrombosis

Due to Ulcer

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Ca Thrombosis Ulcer? duodenum

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Norman M Mann M. D.

Address Sinai Hosp Date signed 9/23/47

G55106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G55106 Registered No.

PLEASE WRITE PLAINLY, with ink or indelible pencil. Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hosp. 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2454 Lakewood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MRS KUTCHER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Michael
13. Birthplace Russia

MOTHER
14. Maiden Name Ida
15. Birthplace Russia

16 (a) Informant Ida Kutcher
(b) Address 2454 Lakewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-20-47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Belair & Conkling Sts

18 (a) Funeral director Jack Lewis Inc
(b) Address 2400 Eastern Ave

19 SEP 25 1947 (Date rec'd by local registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/23/1947, at 5-30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/23/1947 to 7/23/1947, and that I last saw him alive on 7/23/1947.

Immediate cause of death: Diabetes Acidosis
Myocard. infarction
Due to Coronary Thrombosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Irving Cohen
Address Sinai Hosp Date signed 9/23/47 M.D.

Howard J. Mascio M.D.

G55107

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G55102

write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please

G55108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G55108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution:
Lucas 97
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3006 Spaulding Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isidor Rosenbaum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Lena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 68 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Samuel
13. Birthplace Russia

MOTHER
14. Maiden Name Magke
15. Birthplace Russia

16 (a) Informant Lena Rosenbaum
(b) Address 3006 Spaulding Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-25-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phila Rd & Hamilton Ave

18 (a) Funeral director Jack Levin Inc
(b) Address 2120 Eutaw Place

19 (a) SEP 25 1947 (Date rec'd by Registrar) Huntington Williams Mar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-22-1947 at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/43/1947 19..., to 9/22/47 19..., and that I last saw h... alive on 9/13/47 19....

Immediate cause of death Myocardial infarction — Duration

Due to Coronary thrombosis — Duration

Due to Arteriosclerotic heart disease — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature ..... M. D.
Address ..... Date signed 9/24/47

VS 150

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

655109 Dec 16-1889 Sept 24-47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓937

Registered No. 655109

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1621 Morland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-2
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 1621 Morland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Meyers

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bertha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 16-1889

8. AGE: Years 58 | Months 9 | Days 8 | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Merchant

11. Industry or business

FATHER 12. Name unknown

13. Birthplace Russia

MOTHER 14. Maiden Name unknown

15. Birthplace Russia

16 (a) Informant Bertha Meyers

(b) Address 1621 Morland Ave

17 (a) Burial (b) Date thereof 9-26-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Pinedale
Location Belair Rd & Hamilton Ave

18 (a) Funeral director Pace Lewis Inc

(b) Address 2100-02 Eutaw Place

19 SEP 25 1947 (Huntington-Williams Mfg Co)
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-24- 1947, at 9:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June-15-1947 to Sept. 24-1947, and that I last saw h. alive on Sept. 24-1947.

Immediate cause of death	Duration
Acute pulmonary edema	
Due to Cardio-vascular disease	
Due to Coronary heart disease, gen. arteriosclerosis	
Other Conditions Seasonal bronchial asthma	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. Herman Diedel M. D.
Address 2404 Entaw Pl Date signed 9/25/47

X

55110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G55110 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2825 Quesnotary Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-12
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2819 Hilldale Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sol H. Fagan

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mollie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
53			hr. min.

9. Birthplace Russia (Town, County, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name David
13. Birthplace Russia

MOTHER
14. Maiden Name Mary
15. Birthplace Russia

16 (a) Informant Mollie Fagan
(b) Address 2819 Hilldale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-26-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philp Ldr Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 260 Eastern Place

19 (a) SEP 25 194 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-24-47 at 4-8 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/4 1947 to Sept 24 1947 and that I last saw him alive on Sept 24 1947.

Immediate cause of death	Duration
Carcinomatosis probably primary in Liver	2 mos
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Peritoneal Biopsy Aug 47
Major findings of operation: Metastatic Ca of Liver
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Morrison M. D.
Address 11 E Chase St Date signed 9/26/47

X

055111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 124B

Registered No. 055111

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Ky (b) County.....
(c) City or town Louisville (If outside city or town limits, write RURAL and give town)
(d) Street No. 126 So 20th St (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Charles Briskeman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex Male | 5 Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Clara Briskeman

6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) 8-13-80

8. AGE: Years 67 | Months 1 | Days 11 | If less than one day ____ hr. ____ min.

9. Birthplace Russia (town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Frank Briskeman

13. Birthplace Russia

MOTHER 14. Maiden Name Ella Pinsky

15. Birthplace

16 (a) Informant.....

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-25-47 (month) (day) (year)

(c) Cemetery or crematory Louisville Kentucky

Location Jewish Segno Inc

18 (a) Funeral director

(b) Address 240 Eutaw Pl

19 (a) SEP 25 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-24 1947, at 4:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-5 1947 to 9-24 1947, and that I last saw h[illegible] alive on 9-24-1947.

	Duration
Immediate cause of death: Cholemia	1 wk
Due to Portal occlusion of liver	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 9/16/47

Major findings of operation: Portal occlusion of liver + ascites

of autopsy.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature H. Markley M. D.

Address Johns Hopkins Hosp. Date signed 9/24/47

PLEASE WRITE PLAINLY, with ink. Use no abbreviations. In stating cause of death write the causes of death clearly and legibly. correct age is especially important. Physicians: please write

VS 150

X

G55112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G55112

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 804 Stiles St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-2
(e) Length of stay in Baltimore (yrs., mos., or days) 25 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 804 Stiles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marianicola Pallotta

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband Nicola Pallotta
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6 1879

8. AGE: Years	Months	Days	If less than one day
67	9	17	hr. min.

9. Birthplace Larino Campobasso Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Giuseppe Amorosa
13. Birthplace Italy

MOTHER
14. Maiden Name Maddalena Francini
15. Birthplace Italy

16 (a) Informant Robert Piccirilli (Son)
(b) Address 804 Stiles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept.26/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.
18 (a) Funeral director Frank Della Rocca
(b) Address 5[illegible] Morley St.
19 (a) SEP 25 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23, 1947, at 7:00 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 4-15-47 19__, to 9-23-47 19__, and that I last saw h[illegible] alive on 9-23-47 19__.

Immediate cause of death	Duration
Arteriosclerotic Cardiovascular Disease	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John Costantino M.D.
Address 23 E. Lombard Date signed 9-25-47

VS 150

C55113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 25

Registered No. C55113

PLEASE WRITE PLAINLY, with unfading ink. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 806 Mo. 1 Donough St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Viola Stokes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-14-97

8. AGE: Years 25 | Months -3 | Days 8 | If less than one day — hr. — min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Edward Stokes
13. Birthplace Va.

MOTHER 14. Maiden Name Brady Adams
15. Birthplace Va.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Sept 25 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location A A County

18 (a) Funeral director Mrs. Robt A. Ulmer & Son
(b) Address 1329 N. Caroline St.

19 (a) SEP 25 1947 (b)
(Date rec'd by registrar)

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-22 1947, at 8:38 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-21-47 to 9-22 1947 and that I last saw her alive on 9-22 1947.

	Duration
Immediate cause of death Generalized Peritonitis.	
Due to Ruptured tubo inflamatory abscess.	
Due to Pelvic Inflamatory Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Sept 21-1947.

Major findings of operation Generalized peritonitis.

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert P. O'Donnell, M.D.
Address Johns Hopkins Hospital Date signed Sept 23 47

X

G55414

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G55414

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A.
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days) 7 D

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1613 Aisquith St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Amelia

3 (a) FULL NAME Joseph Melvin Bradley (Amelia)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 16 1915

8. AGE: Years: 32 | Months: 11 | Days: 16 | If less than one day: hr. min.

9. Birthplace Bells, Md
(Town, county, and state)

10. Usual Occupation Bartender

11. Industry or business

FATHER
12. Name George O'Melia
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Matched
15. Birthplace Md

16 (a) Informant Elizabeth O'Melia
(b) Address Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 27/47 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem
Location Baltimore Co Md

18 (a) Funeral director Mrs. Dorothy E. Austin
(b) Address 1129 N. Carlton St

19 SEP 25 1947 (Date rec'd by registrar) (b) Kenneth for Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/24 1947, at 3:20 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Pelzenbach M.D.
Medical Examiner.
Date signed 9/24/47

correct age is especially important. Physicians: please write plainly.

G55115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V-13 P

G55115 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be made on this certificate before any copies. Items are important and should be answered fully and accurately. Be sure the cause of death is entered correctly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 623 S. Port St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 -
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(3) Street No. 623 S. Port St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy L. Helton

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Wht	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5 1922

8. AGE: Years	Months	Days	If less than one day
25	2	19	hr. min.

9. Birthplace Baltimore - Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Walter Gabriel
13. Birthplace Pa.

MOTHER
14. Maiden Name Pearl Phillips
15. Birthplace Baltimore, Md

16 (a) Informant James S. Helton
(b) Address 623 S. Port St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/47 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Taylor ave

18 (a) Funeral director Howard N. Bright Jr
(b) Address 4914 Belair Road

19 (a) SEP 25 1947 (Date rec'd by registrar) (b) [illegible] for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25 1947, at 3:02 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to Sept 25 1947, and that I last saw h[illegible] alive on Sept 23 1947.

Immediate cause of death: Pulmonary tuberculosis — Duration 3 yrs.

Due to —

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Leo S. Lapsley M. D.
Address 1121 S. Patterson Park Ave Date signed 9/26/47

VS 150

G55116 BC# B-87602 Hierstetter

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. G55116

PLEASE WRITE LEGIBLY. Use ink. Do not use pencil. Be sure to write the causes of death clearly and legibly. Do not abbreviate. Do not leave any blanks. If unknown, write "unknown." Be sure to give correct age in each case. Every item is especially important. Physicians: please write your diagnosis plainly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2225 West Fayette St
(c) Hospital or institution: Bon Secours Hospital 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1213 W. Cross St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Jean Hierstetter

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	—

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 8/29/47

8. AGE: Years	Months	Days	If less than one day
		26	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name James John Hierstetter
13. Birthplace Maryland

MOTHER 14. Maiden Name Beedle Schmidbauer
15. Birthplace W. Virginia

16 (a) Informant James John Hierstetter
(b) Address 1213 W. Cross St.

17 (a) Burial (b) Date thereof 9-26-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director George L. Bryant
(b) Address 2101 Frederick Ave.

19 (a) SEP 25 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24 1947, at 5:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 22 1947, to Sept. 24 1947, and that I last saw H.E.R alive on Sept. 24 1947

Immediate cause of death	Duration
Terminal Pneumonia	
Due to Congenital heart disease.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Congenital heart disease

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul D. Mannino, M. D.

Address Bon Secours Hosp. Date signed 9/24/47

G55117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 83a

Registered No. G55117

PLEASE WRITE PLAINLY. Use ink. Do not use pencil. Do not abbreviate. Do not write the causes of death clearly and legibly. correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Glen Burnie, 7
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8 Crain Highway S.W.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Matilda R. De Alba

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Louis J. DeAlba

6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) March 13, 1886

8. AGE: Years 61 | Months 6 | Days 10 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation House work

11. Industry or business Own Home

FATHER
12. Name William Henry Baker
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Miller
15. Birthplace Baltimore, Md.

16 (a) Informant Louis J. DeAlba
(b) Address 8 Crain Hwy. S.W. Glen Burnie, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 23, 47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn, R.F.D., Md.

18 (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie, Md.

19 SEP 25 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23 1947, at 4:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1 1947, to Sept 23 1947, and that I last saw her alive on Sept. 23 1947.

Immediate cause of death	Duration
respiratory failure	
Due to Cerebral Vascular Accident	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. C. Durell Jr. M.D.
M. D.

Address Univ. Hosp. Date signed Sept 23

X

G55118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH X 36

Registered No. G55118

PLEASE WRITE PLAINLY. Use ink. Do not use pencil. Do not fold. Do not write above or below the lines. Be sure to write the causes of death clearly and legibly. Give full name of deceased. Do not use initials. Be sure to write correct age in every case. Where any item is unknown, write the word "unknown." Be sure to answer every question. Where none, write "none." Where the exact answer is not known, but an approximate answer can be made, it should be given, and the word "about" should be used. Be sure to write correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Hartford Rd. & Herring Run
(b) Street address Sydenstricker Hospital
(c) Hospital or institution:
Sydenham Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Cecil
(c) City or town Bainbridge Village
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Perkins Cunningham ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Donald Cunningham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-30-22

8. AGE: Years	Months	Days	If less than one day
25	1	25	hr. min.

9. Birthplace Greenburg, W. Virginia
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Brown Perkins
13. Birthplace Greenburg, W. Va.

MOTHER
14. Maiden Name Frances Lester
15. Birthplace Randolph, Ky.

16 (a) Informant Donald Cunningham
(b) Address Bainbridge Valley Rd.

17 (a) Burial (b) Date thereof Sept 25 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Idlewell
Location Port Deposit Md. Rural

18 (a) Funeral director Lee A. Patterson & Son
(b) Address Perryville, Md.

19 (a) SEP 25 1947 (b) Huntington Williams, Md.
(Date rec'd by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-24- 1947, at 2 15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-22- 1947 to 9-24 1947, and that I last saw her alive on 9-24- 1947

Immediate cause of death	Duration
Coron. occp.	20 mins
Failure	
Due to Pulmonary Edema - Bilateral	4 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. O'Crigler, Jr.
Address Sydenham Hosp. Date signed 9-25-47 M. D.

X

G55419

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G55419

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution:
Mercy Hospital 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 627 So. Grundy.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence E. Booz

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1898

8. AGE: Years	Months	Days	If less than one day
49	1	29	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Riveter
11. Industry or business

FATHER
12. Name ? Booz. (Clinton Street)
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary L. Buckley
15. Birthplace Baltimore

16 (a) Informant William C. Booz
(b) Address 627 So. Grundy St.

17 (a) Burial (b) Date thereof 9-27-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Rd.

18 (a) Funeral director John J. Connelly,
(b) Address Essex, Md.

19 (a) [illegible] (Signature of registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24 1947; at 5:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 24 1947, to Sept 24 1947, and that I last saw him alive on Sept. 24 1947.

Immediate cause of death	Duration
Cerebro-vascular accident	1 day
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert Johnson M. D.
Address Mercy Hospital Date signed 9/29/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry of items or information on record is necessary, and to the causes of death clearly and legibly. correct age is especially important. Physicians: please write the

VS 150

X

G55120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 200 C

Registered No. G55120

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 17 N. Schroeder Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EULAH F. VERNON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife James Vernon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 1, 1916

8. AGE: Years 31 | Months 8 | Days 18 | If less than one day hr. min.

9. Birthplace Welch, West Virginia (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Robert Ford

FATHER 13. Birthplace Lynchburg Va.

MOTHER 14. Maiden Name Carrie Pyoung

MOTHER 15. Birthplace Marion Va.

16 (a) Informant Martha McCrary

(b) Address No N. Amity Street

17 (a) (Burial, cremation, or removal) (b) Date thereof Sept 24 '47 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 327 N Schroeder St

19 (a) SEP 25 1947 (Rec'd by registrar) (b) Huntington Williams M.D.

VS 181

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19, 1947, at 7.20 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Undetermined

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ? at ? 25/6 M.

(b) Where did injury occur? Found-ravine- ~~Frankfort & Matson Ave.~~

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Found in ravine

23. Signature George L. Merrill M.D. Medical Examiner.

Date signed 9-22-47

G55421

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G55421
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2335 Lauretta Ave
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Wilhelm F. Ludwig

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-09-9594

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	MARRIED

6 (b) Name of husband or wife MINNIE V. LUDWIG
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) JUNE 16 1900

8. AGE: Years	Months	Days	If less than one day
47	3	8	....hr. ....min.

9. Birthplace BALTO MD
(Town, county, and state)

10. Usual Occupation MECHANIC ELEVATOR CONST.

11. Industry or business OTIS ELEVATOR COR.P.

FATHER
12. Name CONRAD H. LUDWIG.
13. Birthplace GERMANY.

MOTHER
14. Maiden Name ELIZABETH. SCHMIDT.
15. Birthplace GERMANY

16 (a) Informant MINNIE V LUDWIG.
(b) Address 2335 LAURETTA. AVE

17 (a) BURIAL. (Burial, cremation, or removal) (b) Date thereof SEP 27-47 (month) (day) (year)
(c) Cemetery or crematory MEADOWRIDGE MEMORIAL
Location WASHINGTON BLVD

18 (a) Funeral director MRS CHAS A.G. ROHDE
(b) Address 2324 EDMONDSON AVE

19 (a) ..... (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

SEP 25 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24 1947, at 11:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary artery disease

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Emil H. Beyer M.D.
Medical Examiner.

Date signed 9-24-47

X

G55122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G55122

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry must be made for each item. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 330 E 22½ St
(c) Hospital or institution: 12-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 330 E 22½ St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W. Turk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 15-1896

8. AGE: Years	Months	Days	If less than one day
50 51	11	8	hr. min.

9. Birthplace Ala (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Ala

MOTHER 14. Maiden Name Unknown

15. Birthplace Ala

16 (a) Informant Elijah Harrison

(b) Address 2322 Guilford ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-28-47 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director Rayner Sanders

(b) Address 14 12 E Preston St

19 (a) SEP 25 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1947, to Sept 23 1947, and that I last saw h— alive on Sept 22 1947.

Immediate cause of death: Chronic Ulcerated Keloid — Duration: 5 mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis A. Johnson M. D.

Address 2329 Guilford Ave Date signed Sept 26 1947

X

55123 Claude

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G55123

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given. Use typewriter if convenient. Physicians: please correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16 N Fremont Pl
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 16 N Fremont Pl (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James E Bleacher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Laura V

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-25-1872

8. AGE: Years 74 | Months 8 | Days 28 | If less than one day hr. min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Geo Bleacher
13. Birthplace Not Known

MOTHER
14. Maiden Name Horn
15. Birthplace Not Known

16 (a) Informant Mrs Daniel Archer
(b) Address 16 N Fremont Pl

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-25-47 (month) (day) (year)
(c) Cemetery or crematory Ft Mayo
Location Hampden Balto Md

18 (a) Funeral director Geo A Farley
(b) Address Fulton & Fayette

1947 SEP 25 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/22 1947, at 3:0 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/19 1947, to 9/22 1947, and that I last saw h-- alive on 9/19 1947.

Immediate cause of death Coronary Thrombosis — Duration

Due to Chronic Myocarditis

Due to

Other Conditions Senility
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A Bleacher

Address 709 2nd Ave Date signed 9/24/47 M.D.

G55124 BCH 61651

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 64

G55124 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 931 Shields Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Shelton THOMAS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/906

8. AGE: Years | Months: 10 | Days | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Odell Thomas

13. Birthplace Maryland

MOTHER 14. Maiden Name Phillis C Chambers

15. Birthplace Md.

16 (a) Informant Phillis C. Thomas

(b) Address 931 Shields Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/47 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location West Pont. Balto. md

18 (a) Funeral director Metropolitan Funeral Home

(b) Address 927 N. Mordent St.

19 (a) SEP 25 1947 (Date rec'd by registrar) (b) Registration for Williams M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH September 24 1947, at 9:25 P.M.

21 I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry), Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Aspiration of vomitus

Atelectasis of right lung.

~~Dem~~ Status thymico-lymphaticus

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.

Date signed 9/24/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

Registered No. G55125

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun Sts —
(c) Hospital or institution Franklin Square Hospital 2nd ward
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day 9 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 72 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 606 So. East Ave #24 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Conrad Turner

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Mrs. Turner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/25/75

8. AGE: Years 71 | Months 72 yr. 3 mo. | Days 1 day 29 | If less than one day hr. min.

9. Birthplace Maryland —
(Town, county, and state)

10. Usual Occupation Retired —

11. Industry or business

FATHER
12. Name Mr. — Turner
13. Birthplace —

MOTHER
14. Maiden Name Unknown —
15. Birthplace —

16 (a) Informant Mrs. Jennie Turner —
(b) Address 606 So. East Ave #24

17 (a) BURIAL (b) Date thereof 9-27-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL RD.

18 (a) Funeral director LILLY & ZEILER Inc.
(b) Address 1004 S. WOLFE ST.

19 (a) SEP 25 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

55

20. DATE OF DEATH Sept. 24 1947, at 9p M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/23 1947, to 9/24 1947, and that I last saw h. alive on 9/24 1947.

	Duration
Immediate cause of death Intestinal obstruction & severe toxemia	
Due to abdominal adhesions	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 9-24-47

Major findings of operation: intestinal obstruction due to adhesions

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph B Schmeke M. D.

Address Date signed

X

G55126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124

Registered No. G55126

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 3907 Fernhill Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNE B. (DORSCH) WHITE

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widow

6 (b) Name of husband or wife John W. White
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5, 1875

8. AGE: Years	Months	Days	If less than one day
71	9	19	hr. min.

9. Birthplace Howard Co., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Dolphin Dorsch
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mr. Louis C. L'Archeveque
(b) Address 3907 Fernhill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/47 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Cem.
Location Howard Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 25 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/24 1947 at 3:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-22-47 19 to 9-24 1947, and that I last saw h[illegible] alive on 9-24 1947.

Immediate cause of death	Duration
Pneumonia	
Embolism	
Due to Hemorrhage	
Pancreatitis	
Due to Neoplasm	
Other Conditions Chr. Glomerulo Nephritis	

(Include pregnancy within 3 months of death)
Date of operation 9-23-47
Major findings of operation: Fat Necrosis - Hemorrhagic Pancreatitis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. H. Powers Jr. M. D.
Address Union Mem. Date signed 9-25-47

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. In writing the causes of death clearly and legibly. correct age is especially important. Physicians; please write

55127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G55127
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1809 McKean Ave.
(c) Hospital or institution: 1512

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1809 McKean Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY E. SCHEIDT

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife William A. Scheidt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1883

8. AGE: Years	Months	Days	If less than one day
64	0	2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John A/ Sweitzer
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mary Cooper
15. Birthplace Balto., Md.

16 (a) Informant Mr. William A. Scheidt
(b) Address 1809 McKean Ave.

17 (a) Burial (b) Date thereof 9/26/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

1947 SEP 25 1947 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23, 1947, at 11:10M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1947 to Sept 23 1947 and that I last saw Dec alive on Sept 23 1947.

Immediate cause of death
Chronic Myocarditis c
Acute Cardiac Failure

Duration
unknown
2 hrs

Due to

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Cochrane M.D.
Address 1921 W North Ave Date signed 9/24/47 M.D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Erasures or interlineations will void certificate. Please write the causes of death clearly and legibly. Physicians: please write correct age in years, months, days, hours, or minutes, as the case may be. Date of death is especially important.

Attention Medical Examiner

BALTIMORE CITY HEALTH DEPARTMENT

55128 LW 114002

CERTIFICATE OF DEATH

Registered No. G55128

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 564 Oxford St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lucy Carter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18-1880

8. AGE: Years	Months	Days	If less than one day
67	6	6 5	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ? Barber Sid Carter
13. Birthplace Va.

MOTHER
14. Maiden Name Jane ? Barber
15. Birthplace Va.

16 (a) Informant Records- B.C.H.
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 9-26-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Hilliard A. Jacobs
(b) Address 916 Penna. Ave.

19 (a) SEP 25 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23- 1947, at 6:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 22 1947 to Sept. 23 1947, and that I last saw her alive on Sept. 23 1947.

Immediate cause of death	Duration
Respiratory Failure	—
Due to Tetanus	3 days
Due to	over
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulmonary Edema

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmund Gaddess M. D.
Address Balto City Hosp. Date signed 9-26-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

To be Approved by Medical Examiner Affidavit by Howard J. Malecio, M.D.

55129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. 655129

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4202 Parkmount Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4202 Parkmount Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Luella Bushey Frommeyer

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	White	Widowed

6 (b) Name of husband or wife John Worthington Frommeyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1875

8. AGE: Years	Months	Days	If less than one day
72	8	24	hr. min.

9. Birthplace East Berlin, Pa. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Edward J Bushey
13. Birthplace Reading Township, Pa

MOTHER
14. Maiden Name Hannah S. Gardner
15. Birthplace Adams County, Pa.

16 (a) Informant Mrs. Luella
(b) Address 4202 Parkmount

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 9/27/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director Lanahan Funeral Home
(b) Address 401 Belair Rd.

19 (a) SEP 25 1947 (Date rec'd by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 25 1947; at 7:01 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to Sept. 25 1947, and that I last saw her alive on Sept 22 1947

Immediate cause of death Congestive heard failure — Duration 5 mo.
Due to Chr. myocarditis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ronald Jordan M. D.
Address 6077 Harford Rd Date signed 9-25-47

VS 150

X

130 416/61

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45F

Registered No. 055130

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)..... 10
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1123 Webb Ct. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME George Ravenis.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife ?

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 4-23-85

8. AGE: Years 62 | Months 5 | Days 2 | If less than one day .....hr. .....min.

9. Birthplace Europe (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name Paul Ravenis
13. Birthplace Europe

MOTHER
14. Maiden Name Mary ?
15. Birthplace Europe

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/26/47 (month) (day) (year)
(c) Cemetery or crematory Kulpmont Pa.
Location.....

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St

19 SEP 26 1947 (Date received by registrar) (Signature) Evelyn Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept - 25 1947, at 6:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-20-1947 to 9-25-1947, and that I last saw him alive on 9-25-1947

Immediate cause of death	Duration
Bronchopneumonia	
Due to Carcinoma of Tonsil & extension	
Due to Metastatic lymph nodes	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation June 21 '47

Major findings of operation: Ca of tonsil & metastasis

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature W. C. Sanford M.D.
Address Johns Hopkins Hosp. Date signed 9/26/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

55131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 186A

G55131
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1440 N. Gay Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOTTIE TAFT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband ~~or wife~~ Carl Taft

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Sept 1st 1892

8. AGE: Years	Months	Days	If less than one day
55	0	20	....hr. ....min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Michael Antczak
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Carleton Taft
(b) Address 1440 N. Gay St.

17 (a) Burial (b) Date thereof 9/26/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Moreland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) SEP 26 1947 Per instructions for Williams M.D.
(Date rec'd by registrar) Registrar

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21, 1947 at 2.05 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull c intra-cranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9/21/47 at A. M.
(b) Where did injury occur? 1440 N. Gay Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fell down stair steps

23. Signature Carl L. Ryder M.D.
Medical Examiner.
Date signed 9-22-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

55132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓61

Registered No. G55132

AB-100247

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr. 5mos. 26days
(e) Length of stay in Baltimore (yrs., mos., or days) 64yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4009 Glenmore Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Grimm

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Separated

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 21- 1862

8. AGE: Years	Months	Days	If less than one day
85	8	4	hr. min.

9. Birthplace New York City
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Bakery

FATHER
12. Name George Grimm (D
13. Birthplace Germany

MOTHER
14. Maiden Name Sophia Himmel (D
15. Birthplace Germany

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 9/27/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

SEP 26 1947
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION AM

20. DATE OF DEATH Sept-25- 1947, at 11.55M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-29- 1946, to 9-25- 1947 and that I last saw h im alive on 9-25- 1947.

Immediate cause of death (a) Bronchopneumonia

Due to Hypertensive Cardio-vascular Disease

Due to

Other Conditions Diabetes mellitus, mild, arteriosclerosis, senescence

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H Hopkins Jr. M. D.
Address Balt. City Hosp. Date signed 9 Sept 47

VS 150

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to write the cause of death clearly and legibly. Physicians: please write correct age is especially important.

133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. 655133

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Hilton Road
(c) Hospital or institution: Nursing Home 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs 3 mos
(e) Length of stay in Baltimore (yrs., mos., or days) –

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 8
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2245 Cecil Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Alice Lusby

3 (b) If veteran, name war	3 (c) Social Security Account No.
–	–

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife –
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1876

8. AGE: Years	Months	Days	If less than one day
70 71	11	9	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business –

FATHER
12. Name William Lusby
13. Birthplace Baltimore

MOTHER
14. Maiden Name Jennie Cunningham
15. Birthplace Baltimore

16 (a) Informant Mrs. George W. Walker
(b) Address 2245 Cecil Avenue

17 (a) Burial (b) Date thereof 9/27/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto Md

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 SEP 26 1947 Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25 1947, at 7.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 9 1945 to Sept 25 1947 and that I last saw her alive on Sept 11 1947

Immediate cause of death	Duration
Carcinoma of Rectum	2 yrs
Due to	9
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation –
Major findings of operation: –
of autopsy: –

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide –
(b) Date of occurrence – at M
(c) Where did injury occur? – (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? – While at work? –
(Specify type of place)
(e) Means of injury

23. Signature Harry L. Hyde
Address 1100 E North Ave Date signed 9/29/47
M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given as accurately as possible. Be sure to write the causes of death clearly and legibly. correct age is especially important. Physicians: please write

G55134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

G55134 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1608 Mc Elderry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William S. Doutin

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-4879

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 10 1881

8. AGE: Years 66 | Months 1 | Days 10 | If less than one day 14 hr. min.

9. Birthplace Tarboro North Carolina
(Town, county, and state)

10. Usual Occupation Ship Corker

11. Industry or business

FATHER
12. Name Jim Cranshaw
13. Birthplace North Carolina

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Sophia Doutin
(b) Address 1608 McElderry

17 (a) Burial (b) Date thereof Sept 26 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arlington Mem
Location Baltimore County

18 (a) Funeral director Lottie Gross
(b) Address 1408 Ashland Ave.

19 SEP 26 1947 by writing for Williams M.D.
(Date rec'd by registrar) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24, 1947, at 3 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerosis
Cardio - vascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mercer M.D.
Medical Examiner.
Date signed 9-24-47

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

655135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 483a

Registered No. 655135

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1301 Park Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3mo
(e) Length of stay in Baltimore (yrs., mos., or days) 44yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Co. (If outside city or town limits, write RURAL and give town)
(d) Street No. Ruxton Md. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sally Tayloe Compton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Key Compton deceased | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/29/65

8. AGE: Years 81 | Months 8 | Days 25 | If less than one day: hr. min.

9. Birthplace "Mt. Airy" Warsaw, Va. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name William Henry Taylor
13. Birthplace Warsaw, Va

MOTHER 14. Maiden Name Courtenay Chinn
15. Birthplace Warsaw, Va.

16 (a) Informant Dr. Beverley C. Compton
(b) Address Ruxton, Balto. 4, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/47 (month) (day) (year)
(c) Cemetery or crematory Loudin Park
Location Baltimore

18 (a) Funeral director H. W. Mearst Son
(b) Address 805 N. Calvert St.

19 (a) SEP 26 1947 (Date received by registrar) (b) Registrar Wittington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25 1947, at 4:48 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 25 1947 to 9/25 1947, and that I last saw her alive on 9/25 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	4 mo
Due to Arteriosclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Beverley C Compton

Address 1014 St. Paul St. Date signed 9/25/47 M. D.

G55486

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G55486
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1713 Lyon St
(c) Hospital or institution: South Balto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimor (If outside city or town limits, write RURAL and give town)
(d) Street No. 1428 Church St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Raymond Praczewski

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years 58 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Grave digger
11. Industry or business

FATHER
12. Name ?
13. Birthplace Russia

MOTHER
14. Maiden Name ?
15. Birthplace Russia

16 (a) Informant Jo Romanskas
(b) Address 4514 Curtis Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 27 47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem
Location Anundel County

18 (a) Funeral director Joseph Hamilton
(b) Address 602 Washington Blvd

19 (a) SEP 26 1947 (Date rec'd by registrar) (b) Huntington Williamsville Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25 1947, at 3 25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 24 1947, to Sept 25 1947 and that I last saw h[illegible] alive on Sept 25 1947.

Immediate cause of death: Generalized carcinomatosis — Duration
Due to: Carcinoma of the stomach
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation: Lymph node biopsy 1 week ago for diagnosis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Hilton M. D.
Address South Balto Gen. Date signed 9/25/47

X

G55487

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

106 B

G55487
Registered No.

AB-95164

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 30 Albemarle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wladyslau Rupeiko

3 (b) If veteran, name war

3 (c) Social Security Account No. 717-07-7777

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 11-1886

8. AGE: Years	Months	Days	If less than one day
61	1	11	hr. min.

9. Birthplace Lithuania (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Stanley Rupeiko
13. Birthplace Lithuania

MOTHER
14. Maiden Name Josie ?
15. Birthplace Lithuania

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 26-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Joseph Kasunchak Inc
(b) Address 2 E. Washington Blvd

19 (a) SEP 26 1947 (Date rec'd by registrar) (b) Registrar's signature

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept-22- 1947, at 3.15PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1- 1945 to 9-22- 1947 and that I last saw h im alive on 9-22- 1947

Immediate cause of death Respiratory Failure — Duration —
Due to Bilateral Bronalneclan. — 3 years
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Edmund B Beacham M. D.
Address Balto City Hosp Date signed 25 Sept 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

55438 ✓1 BALTIMORE CITY HEALTH DEPARTMENT G55438

CERTIFICATE OF DEATH 1947

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered. If unknown, please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 104 - W. 28th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County Henrico
(c) City or town Richmond Va
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3000 Monument Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Malvina Gregory Smith

3 (b) If veteran, name war

3 (c) Social Security Account No. No

4. Sex: F

5. Color or race: White

6 (a) Single, married, (widowed) or divorced.

6 (b) Name of husband or wife Richard L. Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/7/1876

8. AGE: Years 70 | Months 9 | Days 18 | If less than one day hr. min.

9. Birthplace Chesterfield Co - Va
(Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business

FATHER
12. Name Jas. Cox Gregory
13. Birthplace Chesterfield Co Va

MOTHER
14. Maiden Name Margaret Willard
15. Birthplace Chesterfield Co Va

16 (a) Informant
(b) Address

17 (a) Removal (b) Date thereof 9 - 26 - 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hollywood
Location Richmond Va

18 (a) Funeral director Earl B Robertson
(b) Address 1403 W. Main St

19 (a) SEP 26 1947 (b) Huntington Williams Jr
(Date rec'd by registrar) (Signature of registrar)

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25 1947, at 9.40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1947, to Sept 25 1947 and that I last saw her alive on Sept 25 1947.

Immediate cause of death Cardiac failure with pulmonary edema — Duration

Due to Arteriosclerosis and hypertension

Due to

Other Conditions Renal failure

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard D Hahn

Address Marlborough Apts 1701 Eutaw Place Date signed 9/27/47 M. D.

X

55439

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 170 c

G55439
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 730 E. 37th Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ISABELLE DENNY

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-03-1806

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 14 1895

8. AGE: Years 51 | Months 9 | Days 10 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Seamstress

11. Industry or business Stadium Underwear Co.

FATHER
12. Name George A. Denny
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Fennie M. Davis
15. Birthplace Balto. Md.

16 (a) Informant George P. Denny
(b) Address 3705 Old York Rd

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 9/27/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

19 (a) SEP 26 1947 (Date rec'd by registrar) (b) Huntington Williams Jr M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24, 1947, at 2 P. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture of Skull
Intracranial Hemorrhage

Due to

Other Conditions Paget's Disease (Osteitis Deformans)
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 4-1

(a) Date of injury 9-24-47 1.30 p M.
(b) Where did injury occur? St. Paul & Mulberry Sts.
(c) Did injury occur at home, on farm, industrial place, in public ~~place~~? Public While at work? No
(d) Means of injury Pediastrian-struck by truck

23. Signature Earl L. Kay M.D.
Medical Examiner.
Date signed 9-25-47

VS 151

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G55440

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G55440
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hosp.
(c) Hospital or institution:
13 b
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3310 Beech Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Lowe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/20/47

8. AGE: Years	Months	Days	If less than one day
		5	hr. min.

9. Birthplace Baltimore Md.
(Town) (county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name Elwood Harvin Lowe

13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Viola Day

15. Birthplace Baltimore, Md.

16 (a) Informant Hospital Rec'd.

(b) Address Univ. Hosp.

17 (a) Burial (b) Date thereof 9. 26. 47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St Mary's (Hampden
Location Baltimore Md

18 (a) Funeral director Frank H. Seitz

(b) Address 514 W 36 St

SEP 26 1947 (b) Huntington Mills Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 25 1947, at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/20 1947 to 9/25/47 1947, and that I last saw h[illegible] alive on 9/25/47 1947.

Immediate cause of death	Duration
(a) respiratory failure	
Due to (b) pneumonia + atelectasis	
Due to (c) prematurity	
Other Conditions pneumonia +	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John White M.D.

Address Date signed 9/25/47 M. D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given. Please write the causes of death clearly and legibly. Correct age is especially important. Physicians: please

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. Q55431

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1016 Wood Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Florence Kelly
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 5-1-77
8. AGE: Years 70 | Months 4 | Days 24 | If less than one day hr. min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name George Barton
13. Birthplace Md
MOTHER 14. Maiden Name Martha Porter
15. Birthplace Md.
16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 27/47 (month) (day) (year)
(c) Cemetery or crematory Maryland Park
Location Taylor Ave
18 (a) Funeral director Schenewerk & Wenzman
(b) Address 2615-17 Chestnut Ave
19 (a) SEP 26 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25 1947 at 11a M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 24 1947 to Sept 25 1947 and that I last saw h[e/er] alive on Sept 25 1947

Immediate cause of death	Duration
Myocardial Infarction	
Due to: Arteriosclerosis	
Due to	
Other Conditions: Diabetes Mellitus	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Myocardial Infarction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herman M. Mellinkoff M.D.
Address Johns Hopkins Hosp. Date signed 9/25/47

94a

G55448 BL - 113921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G55448 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 Young Ct. -2
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fred Arrington

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
75 ?			hr. min.

9. Birthplace Orange Co., Va.
(Town, county, and state)
10. Usual Occupation Old Age Pension
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.
17 (a) Burial (b) Date thereof Sept 26 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location Baltimore Md
18 (a) Funeral director Elroy Wilson
(b) Address 1119 Bentley Rd
SEP 26 1947 (Date rec'd by registrar) (Signature) Huntington Williams M.D.

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23 1947, at 8.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 19 1947, to Sept. 23 1947, and that I last saw him alive on Sept. 23 1947.

Immediate cause of death	Duration
Cerebrovascular accident, left	5 days
Due to Arterio sclerosis, cerebral	years
Arterio sclerosis, general	years
Due to Arteriosclerotic Cardio vascular disease c angina	
Other Conditions fibrillation	years.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Laurence Lee Jr.
Address Baltimore City Hosps Date signed 9-25-47
M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

55443

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓112

G55443 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2541 Boarman
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2541 Boarman Ave
(If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Ida Schnaper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Samuel

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 64 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Borah

13. Birthplace Russia

MOTHER 14. Maiden Name Barfa

15. Birthplace Russia

16 (a) Informant Isadore Schnaper

(b) Address 2541 Boarman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-26-47 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Philadelphia Rd - Hamilton Ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 200 Eutaw Place

19 (a) SEP 29 1947 (Date received by registrar) (b) Funeral Home Williams, Md

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-25-1947, at 5P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1925 to Sept 25 1947
and that I last saw h[illegible] alive on Sept 25 1947

Immediate cause of death	Duration
Acute Myocardial infarct.	1 hour
Due to Chronic cor pulmonale	3 years
Due to Bronchial asthma	25 years
Other Conditions Healed pul TB (1920-1922

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Jack Cohen

Address 1804 Eutaw Place Date signed 9/25/47 M. D.

X

G55444

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1643

Registered No. G55444

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital 7 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1000 N. Wolfe Street.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country British West Indies

3 (a) FULL NAME REVERAND THEOPHILUS AUGUSTUS THOMAS

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Irene M. Thomas
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1883

8. AGE: Years	Months	Days	If less than one day
64	-	3	....hr. ....min.

9. Birthplace Jamacia B.W.I.
(Town, county, and state)
10. Usual Occupation Clergyman
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace B.W.I.

MOTHER
14. Maiden Name Unknown
15. Birthplace B.W.I.

16 (a) Informant Irene M. Thomas
(b) Address 829- N. Central Avenue

17 (a) Burial (b) Date thereof Sept. 29, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location.....

18 (a) Funeral director Robert L. Young
(b) Address 1216 N. Carrollton Ave.

19 SEP 26 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

Vs 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24, 1947, at 8.45 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 4-1
(a) Date of injury 9-24-47 at 8.30 P. M.
(b) Where did injury occur? Pier #4-Pratt St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Jumped into water

23. Signature [signature] M.D.
Medical Examiner
Date signed 9-25-47

X

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G55443

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

G55448 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2307 Druid Hill Ave.
(c) Hospital or institution: 13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2307 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARCELLA GROOMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife James A. Grooms
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1859

8. AGE: Years	Months	Days	If less than one day
87	10	13	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Hall
13. Birthplace Md.

MOTHER
14. Maiden Name Hannah Nelson
15. Birthplace Md.

16 (a) Informant Mr. Nelson Grooms
(b) Address 2307 Druid Hill Ave.

17 (a) Burial (b) Date thereof 9-26-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Jesse W. Redden
(b) Address 436 W. Biddle St.

19 (a) SEP 26 1947 Filed by registrar Wellington Williams Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23, 1947, at 5:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-16- 1947 to 9-23 1947, and that I last saw h[illegible] alive on 9-23- 1947

Immediate cause of death	Duration
Cerebral Hemorrhage	7 Day
Due to Arteriosclerosis	6 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L Goodwin Higgins M. D.
Address 7073 Eastern Ave Date signed 9/25/47

X

055446

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

055446 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3308 Rosekemp Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3308 Rosekemp Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth J. Jacob

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife George D. Jacob
6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Apr 4. 1864

8. AGE: Years	Months	Days	If less than one day
83	5	21	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name George Willershausen
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Hilda E. Wyrsbacher
(b) Address 3308 Rosekemp Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 27-1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director Mrs. John W. Teufel's Son
(b) Address 5311 Edmondson Ave

19 (a) SEP 26 1947 (Date rec'd by registrar) (b) Huntington Williamsport Md

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25 1947 at 10 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1947 to Sept 25 1947 and that I last saw her alive on Sept 24 1947

Immediate cause of death	Duration
Pneumonia Pulmonary Tuberculosis	14 da
Due to Myocarditis Arteriosclerosis	11 day
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S P A Stevens M. D.
Address 7878 Harford Rd Date signed 9-25-47

X

G55447

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G55447

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2208 Fenwick Ave
(c) Hospital or institution: Dora
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2208 Fenwick Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dora Charlotte Leitch

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widow

6 (b) Name of husband or wife John V. Leitch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1859

8. AGE: Years	Months	Days	If less than one day
87	11	19	hr. min.

9. Birthplace Bremen, Germany
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name -- Lange
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Emil L. Leitch, son
(b) Address 3502 Cedardale Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/29/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 26 1947 (Date rec'd by registrar) (b) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/25 1947, at 11:20 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 9/26/47

55448

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

G55448
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Lombard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 39

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 812 Eastern Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Pezzica

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of ~~husband or~~ wife Rosa Pezzica
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 8 1882

8. AGE: Years	Months	Days	If less than one day
65	1	17	hr. min.

9. Birthplace Carrara Italy
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Pietro Pezzica
13. Birthplace Italy

MOTHER
14. Maiden Name Ida Boni
15. Birthplace Italy

16 (a) Informant Rosa Pezzica (Wife)
(b) Address 812 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 29/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road Baltimore Md.

18 (a) Funeral director Arcuili Della Rose
(b) Address 52 N. Marley St.

19 SEP 26 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/25/47 19 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/9 1947 to 9/25 1947 and that I last saw him alive on 9/25 1947.

Immediate cause of death	Duration
Cerebral Aneurysm	
Due to Cerebral Arteriosclerosis	
Due to Hypertension, Portal Cirrhosis	
Due to Infection, Surgical	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation none performed
Major findings of operation:
of autopsy: not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature D. B. Peyton Jr. M. D.
Address University Hosp. Date signed 9/25/47

X

G55449 G55449

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 706 S.Durham Street
(c) Hospital or institution:
Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, 31.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 706 South Durham Street
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Walenty J.Dobrzykowski (Darby)

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of [redacted] wife. Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan, 2, 1879

8. AGE: Years 68 | Months 8 | Days 23 | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name Joseph Dobrzykowski
13. Birthplace Poland

MOTHER
14. Maiden Name Anna Lewandowski
15. Birthplace Poland.

16 (a) Informant Mrs. Anna Dobrzykowski
(b) Address 706 South Durham Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-29-49 (month) (day) (year)
(c) Cemetery [redacted] Holy Rosary
Location Baltimore-Co, Md.

18 (a) Funeral director George A. Weber
(b) Address 705 South Ann Street

19. Date received by Registrar SEP 26 1947 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25th 1947, at 9 15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1945 to Sept 25 1947, and that I last saw h[redacted] alive on Sept 23 1947.

	Duration
Immediate cause of death Hypostatic Arteriosclerotic C.V. Disease	
Coronary Thrombosis	July 1947
Due to Coronary Occlusion	9-22-47
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edj Schimunek M. D.
Address 842 N Eutaw Date signed 9-26-47

PLEASE WRITE PLAINLY, with ink. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

VS 3

G55450

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 131a

G55450 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 807 N Gay St.
(c) Hospital or institution: 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits write RURAL and give town)
(d) Street No. 807 N. Gay St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roberta Scott Harwell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: Wh.

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Waverly

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20, 1895

8. AGE: Years	Months	Days	If less than one day
52	4	2	hr. min.

9. Birthplace Surry County Va
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Andrew Scott
13. Birthplace Va.

MOTHER
14. Maiden Name Melinda Pegram
15. Birthplace Va.

16 (a) Informant Waverly Harwell
(b) Address 807 N. Gay St

17 (a) Burial (b) Date thereof Sept 26 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Q. G. County Md

18 (a) Funeral director Mrs. Pitt-Gallion
(b) Address 112 S Dicarlins St

19 (a) SEP 26 1947 (b) Huntington Williams M.D.
(Date received by registrar)

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 22 1947, at 2:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/17 1947, to 9/22 1947, and that I last saw her alive on 9/22 1947

Immediate cause of death	Duration
Coronary thrombosis	5 days
Due to hypertensive cardiovascular	
Due to disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature. Rayner Browne

Address 1510 E. Madison St Date signed M 9 D 26/47

Rayner Browne X

655451

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131A

655451 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2075 Rockrose Ave.
(c) Hospital or institution Ardleigh Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 wks
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4106 Falls Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Nathaniel Myles

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-03-4988

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Ella B. Myles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1-1872

8. AGE: Years	Months	Days	If less than one day
75	8	24	hr. min.

9. Birthplace Baltimore, Maryland (Town, county and state)

10. Usual Occupation Shipping Clk.

11. Industry or business Linen Thread Co.

FATHER
12. Name Nathaniel P. Myles
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary P. Purdew
15. Birthplace Maryland

16 (a) Informant Millard E. Myles
(b) Address 4106 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 27 1947 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) SEP 26 1947 (Date rec'd by registrar) (Entering for Williams, M.D.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25 1947, at 5:40 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 10, 1947 to Sept 25, 1947 and that I last saw him alive on Sept 24 1947

Immediate cause of death	Duration
Arteriosclerotic C.V.R. Dis.	
Due to	
Due to	
Other Conditions Hypostatic Pneumonia (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward F. Williams M.D.
Address 9037 Falls Rd. Date signed 9/25/47

X

A 75 150—

G55452

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered No. G55452

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1413 Bank Street
(c) Hospital or institution: 3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1413 Bank St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Sauer

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	WIDOW

6 (b) Name of husband or wife Frank A. Sauer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1871

8. AGE: Years	Months	Days	If less than one day
75	11	18	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation President of
11. Industry or business Frank A. Sauer Cooperage

FATHER
12. Name George Mueller
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Leonhardt
15. Birthplace Germany

16 (a) Informant Miss Helen E. Sauer
(b) Address 1413 Bank St.

17 (a) Burial (b) Date thereof Sept. 28-
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location Baltimore Md.

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address 1649 E. North Ave

19 (a) SEP 26 1947 (b) Huntington Wilmington, Md.
(Date rec'd by registrar)

V S 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23 1947, at 6:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 9 1947 to Sept 23 1947, and that I last saw h alive on Sept 23 1947.

Immediate cause of death	Duration
Pulmonary Edema	1 day
Hypostatic Pneumonia	1 day
Due to Cerebral apoplexy (Acute stroke)	3 mins
Due to Arteri-Sclerosis	Unknown
Other Conditions Right side hemi-plegia	3 mos

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature A. F. Rees M. D.
Address 24 S. Mary Date signed Sept 24/47

X

G55453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G55453

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1612 N. Bond Street
(c) Hospital or institution: 8

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1612 N. Bond Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY LOUISE JOHNSON

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Iver Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27, 1860

8. AGE: Years	Months	Days	If less than one day
87	2	29 28	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John DeParp
13. Birthplace France

MOTHER
14. Maiden Name Helena Sinaky
15. Birthplace Germany

16 (a) Informant Mrs. Dora Clark
(b) Address 1612 N. Bond Street

17 (a) Burial (b) Date thereof 9-27-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) SEP 26 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 25 1947, at 10:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 2 1947, to Sept 25 1947, and that I last saw h[illegible] alive on 19

Immediate cause of death	Duration
Cardiac Dilatation	1 day
Due to Myocardial Insufficiency	5 yrs.
Due to General Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [signature] M. D.
Address 2025 E. North Ave. Date signed 9-25-47

X

G55454

BALTIMORE CITY HEALTH DEPARTMENT X
CERTIFICATE OF DEATH 1937

Registered No. G55454

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Avenues
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2033 Gwynn Oak Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel C. Mahle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Delia A. Mahle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1871

8. AGE: Years	Months	Days	If less than one day
76	7	16	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John C. Mahle
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Gerwig
15. Birthplace Md.

16 (a) Informant Mrs. Delia A. Mahle
(b) Address 2033 Gwynn Oak Ave

17 (a) Burial (b) Date thereof Sept 29 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem
Location Woodlawn Baltimore Co Md.

18 (a) Funeral director E. Kelly Carnegan
(b) Address 510 Liberty Heights Ave

SEP 28 1947

19 (a) (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/25 1947 at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/16 1947 to 9/25 1947 and that I last saw him alive on 9/25 1947.

Immediate cause of death	Duration
Heart Failure	
Due to Hypertensive Cardio-Vascular Disease	
Due to	
Other Conditions Uremia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James C. Hamill M.D.
M. D.
Address St Agnes' Hosp Date signed Sept 27 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C55455

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

C55455 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wayne Ave & Highland St.
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 31 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Baltimore
(If outside city limits, write RURAL, and give town)
(d) Street No. 4033 Fairfax Rd (West Baltimore General Hospital)
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Fried

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-24-47.

8. AGE: Years	Months	Days	If less than one day
—	—	1	31 hr. min.

9. Birthplace Baltimore md.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Meyer Zelig Fried
13. Birthplace Baltimore Maryland.

MOTHER
14. Maiden Name Claire Adele Nderior
15. Birthplace Baltimore Maryland.

16 (a) Informant Claire Adele Fried
(b) Address 4033 Fairfax Rd.

17 (a) Burial (b) Date thereof 9 26 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Roselawn
Location Hamilton Ave

18 (a) Funeral director Sol Leinwand Bro
(b) Address 1124-26 W North Ave

19 (a) SEP 26 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/26/47 19 at 31 hrs M

21. I certify that death occurred on the date above stated; that I attended deceased from 7:48 PM 9/24/47 to 31 hrs 9/26/47 and that I last saw her alive on 9/26/47

Immediate cause of death
Premature birth — Duration
Due to —
Due to —
Other Conditions Twin triple pregnancy
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Thomas S. Waldron M.D.
Address W B GR Date signed 9/26/47

G55456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G55456

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Dukeland St.
(c) Hospital or institution:
West Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 21 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL or give town)
(d) Street No. 4033 Fairfax Rd
(If rural give location) Hospital
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Fried # 11

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-24-47.

8. AGE: Years	Months	Days	If less than one day
—	—	—	21 hrs min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Meyer Zelig Fried
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Claire Adele Milstein
15. Birthplace Baltimore Maryland

16 (a) Informant Claire Adele Fried
(b) Address 4033 Fairfax Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 26 47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bro
(b) Address 1124-26 W North Ave

19 (a) SEP 26 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/25/47 19 at 3:45 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 7:30 P.M 9/24/47 to 3:45 9/25 1947.
and that I last saw h.R. alive on 9/25/47 19

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions Multiple Pregnancy	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frances L. Greenstine M.D.
Address W. Balt. Gen. Hosp. Date signed 9/25/47

G55457

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 186a

Registered No. G55457

PLEASE WRITE PLAINLY, with unfading ink. Entries must be made in permanent black ink or typewritten. Do not use abbreviations. If data are unknown, write the words "unknown" or "none" so that no space may be left for additions. Physicians: please write the causes of death clearly and legibly. Underlining is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2516 arbutus ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George H. Oakes

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 212-05-5076
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Gladys M. Oakes
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): July 3 1896
8. AGE: Years: 51 | Months: 2 | Days: 21 | If less than one day: hr. min.
9. Birthplace: Virginia (Town, county, and state)
10. Usual Occupation: Carpenter
11. Industry or business: Gas & Elec Co

FATHER
12. Name: George Hamit Oakes
13. Birthplace: Virginia

MOTHER
14. Maiden Name:
15. Birthplace:

16 (a) Informant: Alma M. Oakes
(b) Address: 2516 Arbutus Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/29/47 (month) (day) (year)
(c) Cemetery or crematory: Meadowridge
Location: Washington Blvd.
18 (a) Funeral director: John C. Mellyn
(b) Address: 2435 E. Oliver St.
19 (a) SEP 26 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24 1947, at 1:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pulmonary edema
Subarachnoid hemorrhage
Due to
Other Conditions Compound fract. of left femur; Fracture 4th & 5th st.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-23-47 at 5:00 P.M.
(b) Where did injury occur? Pratt St. & Smith's Wharf Pier #4 - Pratt St.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? yes
(d) Means of injury: Fell while erecting scaffold

23. Signature [signature] M.D.
Medical Examiner.
Date signed 9-24-47

G55458 AB-114033 004 B 88548

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 157E

G55458 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2041 Harlem Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gregory Johnson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 27- 1947

8. AGE: Years	Months	Days	If less than one day
		28	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Otis McLain Johnson
13. Birthplace N.C.

MOTHER
14. Maiden Name Rosemary Williams
15. Birthplace Md.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 9-27-47
(burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location C. L. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 SEP 26 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION AM

20. DATE OF DEATH Sept-25- 1947, at 12.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-23- 1947 to 9-25- 1947, and that I last saw h im alive on 9-25- 1947.

Immediate cause of death	Duration
Cardiac Failure	1 day
Due to Congenital Heart Disease	1 month
Due to	
Other Conditions Blind. Def. 6th finger deformed foot	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy Congenital Heart Disease, etc.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Julian L. Griffin M. D.
Address Bal't. City Hosps. Date signed Sept 25 1947

VS 150

G55459

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G55459

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Greene
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Ellicott City (If outside city or town limits, write RURAL and give town)
(d) Street No. Waterloo Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Taylor.

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-2956

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Nettie Hooper

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 6, 1888

8. AGE: Years 58 | Months 10 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Supervisor

11. Industry or business Balto. News.

FATHER
12. Name William Taylor
13. Birthplace Maryland

MOTHER
14. Maiden Name Ford Akers
15. Birthplace Maryland

16 (a) Informant Mrs Nettie Taylor
(b) Address Waterloo Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9.29.47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd

18 (a) Funeral director Harry H. Wiltze
(b) Address 4101 Edmondson Ave.

19 (a) SEP 26 1947 (Date rec'd by registrar) (b) Cunningham Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-25 1947, at 5.00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-2- 1947, to 9-25 1947, and that I last saw him alive on 9-25- 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Adenocarcinoma Lung, multiple Metastasis	
Due to Secondary to Adenocarcinoma of Left Breast	
Other Conditions Pneumonitis	

(Include pregnancy within 3 months of death)
Date of operation Aug 28, 1947
Major findings of operation: Adeno Carcinoma of L. Breast
of autopsy: Refused.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. L. Jamison M. D.
Address University Hosp Date signed 9-25-47

X

G55460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G55460

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2706 W. Franklin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2706 W. Franklin St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sodona L. Greenwood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John Greenwood

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 2, 1864.

8. AGE: Years 83 | Months 6 | Days 22 | If less than one day hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Louis J. Ellis
13. Birthplace Md.

MOTHER
14. Maiden Name Susan McDonald
15. Birthplace Md.

16 (a) Informant Wm. H. Winkel
(b) Address 2706 W. Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3501 Frederick Rd.

18 (a) Funeral director Harry H. Wirtzke
(b) Address 4101 Edmondson Ave.

19 (a) SEP 26 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24/47, 19..., at ... M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 1947 to 9/24 1947 and that I last saw h[e]r alive on 9/24 1947

Immediate cause of death	Duration
Cerebral Hemorrhage	3 days
Due to Arterial Sclerosis	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. H. Carter M. D.
Address 2145 W. Balto St. Date signed 9/25/47

G55461

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G55461 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 605 Pontiac Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County X Balto
(c) City or town 605 Pontiac Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore Md
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James W Fisher

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Kate Fisher

6 (c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): Jan 20 1872

8. AGE: Years: 75 | Months: 8 | Days: 3 | If less than one day: hr. min.

9. Birthplace: Va (Town, county, and state)

10. Usual Occupation: Railroad

11. Industry or business: B & O.

FATHER
12. Name: Wm C Fisher
13. Birthplace: Va

MOTHER
14. Maiden Name: Mollie Grubbs
15. Birthplace: Va

16 (a) Informant: Mrs Kate Fisher
(b) Address: 605 Pontiac ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 29 (month) (day) (year)
(c) Cemetery or crematory: Cedar Hill
Location: Rural

18 (a) Funeral director: Ullrich Funeral Home
(b) Address: 200 E Orleans St

19 (a) SEP 26 1947 (Date rec'd by Registrar) Registration for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23 1947, at 8 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1/47 19 , to 9/23 1947 and that I last saw him alive on 9/23 1947

	Duration
Immediate cause of death: CARdiac FaiLure	2 days
Due to: CoRonARy THRomBosis	3 wks.
Due to: ARteRioSclerosis	?
Other Conditions: GeneRALiSed ARTERIoSCleRoSiS (Include pregnancy within 3 months of death)	?

Date of operation 8/22/47

Major findings of operation: Chronic ost Lomyelitis; Arteriosclerosis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. F. Williamson M.D.

Address 3326 Frederick Ave Date signed 9/25/47

V S 150

G55462

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G55462

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 405 E. Clement St.
(c) Hospital or institution: 24
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 405 E. Clement St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Katherine D. Moeser

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Henry E. Moeser
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 2- 1895

8. AGE: Years	Months	Days	If less than one day
51	9	23	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation
11. Industry or business Housewife

FATHER
12. Name Michael Cuddy
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Madelene A. Landers
15. Birthplace Richmond Va

16 (a) Informant Henry E. Moeser
(b) Address 405 E. Clement St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-29-1947 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md

18 (a) Funeral director Flynn & Flynn
(b) Address 1476 Light St.

19 (a) SEP 26 1947 (Date rec'd by Reg.) (b) Everington Williams M.D. (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 25 1947, at 3:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10 1947, to Sept 25 1947, and that I last saw h[illegible] alive on Sept 24 1947

Immediate cause of death: Myocardial Insufficiency — Duration

Due to

Due to

Other Conditions Arterio Sclerosis - Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John C. Behrmesch

Address 1335 S. Charles St Date signed 9/26/47

VS 150

655463

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered 655463

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 504 Allendale St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 M
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 504 Allendale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nancy C. McHugh

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Frank M. McHugh
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25-1892

8. AGE: Years	Months	Days	If less than one day
55	6	-	hr. min.

9. Birthplace Lexington Va (Town, county, and state)
10. Usual Occupation
11. Industry or business Housewife

FATHER
12. Name Harry E. Birmingham
13. Birthplace Lexington Va

MOTHER
14. Maiden Name Harriett Parsley
15. Birthplace Virginia

16 (a) Informant Frank M. McHugh
(b) Address 504 Allendale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-28-1947 (month) (day) (year)
(c) Cemetery or crematory Presbyterian
Location Lexington Virginia

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 (a) Date received by registrar SEP 29 1947 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/25 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6 1946, to 9/25 1947 and that I last saw H.R.M. alive on 9/20 1947.

Immediate cause of death	Duration
Cerebral Vascular Failure	1 Month
Due to Metastatic Carcinoma	1 Year
Due to Carcinoma Of The Rectum	18 Months
Other Conditions Bronchial Asthma (Include pregnancy within 3 months of death)	
Date of operation 6/46	
Major findings of operation: Carcinoma Of The Rectum	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Huntington Williams M.D.
Address 3629 Edmondson Ave Date signed 9/26/47

VS 150

G55464

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

A57831 / 130

Register No. G55464

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Prince Georges
(c) City or town Laurel
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route #2
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Melvin McDaniel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1946

8. AGE: Years	Months	Days	If less than one day
1			.....hr. .....min.

9. Birthplace N. Mexico (Town, county, and state)
10. Usual Occupation.....
11. Industry or business

FATHER
12. Name Melvin McDaniel
13. Birthplace Okla.

MOTHER
14. Maiden Name Madeline Lowther
15. Birthplace W. Va.

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 27 1947 (month) (day) (year)
(c) Cemetery or crematory Emmanuel
Location Baggerstown, Md.

18 (a) Funeral director Wm. H. Hyndman
(b) Address Laurel, Md.

19 (a) SEP 26 1947 (Date rec'd by registrar) (b) Transcription for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept - 26 1947 at 6 00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-23 1947 to 9-26 1947 and that I last saw him alive on 9-26 - 1947.

Immediate cause of death	Duration
Uremia	
Due to Subacute Nephritis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... (Specify type of place) While at work?.....
(e) Means of injury.....

23. Signature W M Edmunds Jr
Address J. H. H. Date signed 9-26-47

X

G55465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 163 H

Registered No. G55465

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1405 E. Baltimore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1405 E. Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Makelon (Makelon)

3 (b) If veteran, name war
(c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Frank
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1, 1916

8. AGE: Years	Months	Days	If less than one day
31	1	25	hr. min.

9. Birthplace Coal-land, Va. (Town, county, and state)
10. Usual Occupation Comfort. springs
11. Industry or business

FATHER
12. Name Albert A. Taylor
13. Birthplace Sylvatus, Va.

MOTHER
14. Maiden Name Anna Bunkley
15. Birthplace Meimendow, Va

16 (a) Informant James Taylor
(b) Address 1405 E. Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/26/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem
Location Pulaski Va.

18 (a) Funeral director Wendell J. Diffel
(b) Address 312 S. Highland Ave

19 SEP 26 1947 (Date received by Registrar) (Signature) John Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-26- 1947 at 8 15 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH asphyxiation due to illuminating gas.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9/26/47 at 3-1 A.M.
(b) Where did injury occur? 1405 E. Balto St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury 5 burners of kitchen stove open + two + vent.

23. Signature Emil L. Kraus M.D. Medical Examiner.
Date signed 9-26-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given, if known, or correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 131

855466

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 47D

G55466 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be entered, or a delay in the issuance of a burial permit may result. Give the causes of death clearly and legibly. correct age is especially important. Physicians: please write the c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1902 Kennedy Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1902 Kennedy Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Oliver B Wentling

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-14-6380

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Clara

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2. 1884

8. AGE: Years 63 | Months 3 | Days 24 | If less than one day hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Tobacco Co

MOTHER / FATHER

12. Name Charles E Wentling

13. Birthplace Va

14. Maiden Name Miranda C Dickens

15. Birthplace Md

16 (a) Informant Robert L Wentling

(b) Address 3147 N Lowen St Balto

17 (a) Cremation (b) Date thereof 9/27/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudale

Location Baltimore Md

18 (a) Funeral director Wilhelm & Son

(b) Address 1270 Lombard St

19 (a) SEP 27 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 26 1947 at 5:25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to Sept 26 1947, and that I last saw h-- alive on Sept 25 1947

Immediate cause of death Pulmonary Hemorrhage — Duration 2 days

Due to Carcinoma of the Lungs — 1 yr.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul H. Holmes M.D.

Address 3700 Park Heights Ave Date signed Sept 26 1947

VS 3

Dr. Known 1938 W. North Ave - Ma 6044

G55467

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 97

Register G55467

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 741 W. North Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 741 W. North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dallius E. Biggs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife: Louise E. Biggs

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 24th 1864

8. AGE: Years 83 | Months — | Days 1 | If less than one day hr. min.

9. Birthplace Trenton Tenn. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Substenance Farming Manufacturing

FATHER
12. Name Jeremiah R. Biggs
13. Birthplace Trenton Tenn.

MOTHER
14. Maiden Name Mary E. Roberts
15. Birthplace Trenton Tenn

16 (a) Informant Helyar V. Biggs
(b) Address 741 W. North Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 9/27/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Meadow Ridge
Location Dorsey Md

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) SEP 27 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25th 1947, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 22 1947 to Sept 25 1947, and that I last saw him alive on Sept 22 1947.

	Duration
Immediate cause of death: Hypostatic Pneumonia	4 days
Due to: General Arterio Sclerosis	Several Years
Due to: Old Age	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. W. Known

Address 1938 Linden Ave Date signed 9/25/47 M. D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C55468

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. C55468

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1615 E. Lanvale St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Anna E Dubbs

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Philip R. Dubbs
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/26/99

8. AGE: Years 48 | Months 7 | Days — | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name George January
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Anna Lantz
15. Birthplace Balto. Md.

16 (a) Informant Philip R Dubbs
(b) Address 1615 E. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/30/47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (b) SEP 27 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/26 1947 at 1 35 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/26 1947 to 9/26 1947 and that I last saw her alive on 9/26 1947.

Immediate cause of death	Duration
Complete heart block.	
Due to Arteriosclerotic heart disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Coronary sclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert E May M. D.
Address St. Joseph's Hosp Date signed 9-26-47

VS 150

X

G55469

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G55469

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2075 Rockrose Ave
(c) ~~Hospital or~~ institution: Ardleigh Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 502 Mt. Holly St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma V. McKenna

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband Arthur J. McKenna
6 (c) If alive, give age ___ years

7. Birth date of deceased (mo., day, yr.) April 8th 1872

8. AGE: Years	Months	Days	If less than one day
75	5	16	___ hr. ___ min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER
12. Name William Rupp
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary A. Meyers
15. Birthplace Balto. Md.

16 (a) Informant Mary C. Rupp
(b) Address 502 Mt. Holly St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 9/29/47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) SEP 27 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24th 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/17 1947 to 9/24 1947, and that I last saw her alive on 9/24 1947.

Immediate cause of death	Duration
Cardiac Asthma.	4 hr.
Due to Hypertension.	5 yr.
Due to Cerebral Hemorrhage	3 da.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E W Towers M. D.
Address 1202 Park Ave Date signed 9/26/47

VS 150

G55470

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83A

Register G55470

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3922 Maine Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3922 Maine Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT C. HARDIN

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widower

6 (b) Name of husband or wife Lillie Mae Hardin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 29, 1868

8. AGE: Years	Months	Days	If less than one day
79	7	3	hr. min.

9. Birthplace Talbot Co., Md.
(Town, county, and state)
10. Usual Occupation Commission Merchant
11. Industry or business Self

FATHER
12. Name Robert Hardin
13. Birthplace Talbot Co., Md.

MOTHER
14. Maiden Name Elizabeth Pastorfield
15. Birthplace Talbot Co., Md.

16 (a) Informant Mr. P. T. Hardin
(b) Address 3315 Rosekemp Ave.

17 (a) Burial (b) Date thereof 9/27/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Spring Hill Cem.
Location Easton, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 27 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25, 1947 at 12 40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/12 1938 to 9/25 1947 and that I last saw him alive on 9/25 1947

Immediate cause of death	Duration
Cerebral thrombosis	3 days
Due to Pulmonary edema	1 day
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert G. Reite, M.D.
Address 3408 Windsor Ave. Date signed 9/26/47

VS 150

G55471

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

G55471 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3812 Fairview Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 9
(e) Length of stay in Baltimore (yrs., mos., or days) 5 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3812 Fairview Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rachel Minerva Carnel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~ widow

6 (b) Name of husband or wife Robt. Carnel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 12 1871

8. AGE: Years 76 | Months 7 | Days 14 | If less than one day hr. min.

9. Birthplace Dauphin County, Pa (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John H. Carnel
13. Birthplace Dauphin Co. Pa.

MOTHER 14. Maiden Name Rebecca Hassel
15. Birthplace Dauphin Co. Pa.

16 (a) Informant Roy H. Carnel
(b) Address 3812 Fairview Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 29 1947 (month) (day) (year)

(c) Cemetery or crematory East Harrisburg
Location Harrisburg Pa

18 (a) Funeral director Willard J Tuckner + Sons
(b) Address North + Pennsylvania Ave

19 (a) SEP 27 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1947, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to Aug 1947 and that I last saw h[illegible] alive on Aug 10 1947

Immediate cause of death Cardiovascular disease

~~Due to~~ & hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles L. Warner M. D.

Address 426 Med Arts Baltimore, Md Date signed 9/26/47

G55472

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

185

Registered No. G55472

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr. 15 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Victory Villa
(If outside city or town limits, write RURAL and give town)
(d) Street No. 117 Randolph Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mike Stefano (Michael)

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or~~ divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Anna Stefano
6 (c) If alive, give age ~~41~~ years

7. Birth date of deceased (mo., day, yr.) Sept 25 - 1906

8. AGE: Years	Months	Days	If less than one day
41	0	18	hr. min.

9. Birthplace Pa
(Town, county, and state)
10. Usual Occupation Garbage Collector
11. Industry or business Balto. County

FATHER
12. Name Harry Stefano
13. Birthplace Unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Lois Stefano
(b) Address 117 N. Randolph Rd Victory Villa
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/29/47 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Sollyppos Md
18 (a) Funeral director Milburn Lodge Sons
(b) Address 1217 H Towl St
19 SEP 27 1947 (Date rec'd by registrar) (Transcription for Williams, M.D.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 25, 1947, at 7 15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock
due to hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 53-00
(a) Date of injury 9/25/47 at approx. 5:20 P.M.
(b) Where did injury occur Middle River Road & Bird River Road
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury caught in circular saw while in boat

23. Signature M.D.
Medical Examiner
Date signed 9-26-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G55473

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 520

Registered G55473

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: Balto. 13 Md St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Dorchester
(c) City or town Hooperesville, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Tyler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22 1874

8. AGE: Years	Months	Days	If less than one day
73	7	4	hr. min.

9. Birthplace Hooperesville Md (town, county, and state)
10. Usual Occupation Some duties
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Frances Parr
(b) Address daughter

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 28 47 (month) (day) (year)
(c) Cemetery or crematory Methodist Cem.
Location Hooperesville Dor. Co. Md

18 (a) Funeral director John D. Mitchell & Son
(b) Address 1414 Eutaw Place

19 Date rec'd (by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/26 1947 at 3:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/20 1947 to 9/26 1947 and that I last saw h~~er~~ alive on 9/26 1947

Immediate cause of death Cardio Respiratory Failure — Duration
Due to Metastatic Carcinoma
Due to of Bladder
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Harry T. Wilson Jr. M. D.
Address St. Joseph's Hospital Date signed 9/26/47

X

G55474

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 1568

G55474 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 da.
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town LOGAN.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 321 Stratton St
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Fay L. Tiller

3 (b) If veteran, name war —

3 (c) Social Security Account No. 236-01-7783

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	married

6 (b) Name of husband or wife Elma Tiller
6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) 8-11-04

8. AGE: Years	Months	Days	If less than one day
43	1	15	..... hr. ..... min.

9. Birthplace W. Va. Williamson
(Town, county, and state)
10. Usual Occupation Mechanic
11. Industry or business Contractor Industry

FATHER
12. Name Thomas Tiller
13. Birthplace W. Va.

MOTHER
14. Maiden Name Eliza Jude
15. Birthplace W. Va.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof SEPT. 28, 1947 (month) (day) (year)
(c) Cemetery or crematory Family Cemetery (Tillers)
Location Logan W. Va.

18 (a) Funeral director Walter Burgess Bradley
(b) Address 1922 W. Tenth Avenue

19 (a) SEP 27 1947 (Date rec'd by registrar) (b) Huntington W. Va.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26 - 1947 at 6 07 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-20 - 1947 to 9-26 - 1947 and that I last saw him alive on 9-26 - 1947.

Immediate cause of death myasthenia gravis — Duration 2 1 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jos Sisson M.D.
Address Johns Hopkins Hosp Date signed 9-27-47

1

G55475

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G55475

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2341 Annapolis Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2341 Annapolis Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Jw. Krauss

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Samuel L. Krauss
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 18 1876

8. AGE: Years 71 | Months 6 | Days 8 | If less than one day hr. min.

9. Birthplace Cecil Co. Md.
(Town, county and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER
12. Name Joshua McCauley
13. Birthplace Unknown.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Samuel L. Krauss
(b) Address 2341 Annapolis Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 30-1947 (month) (day) (year)
(c) Cemetery or crematory Brookview Cemetery
Location Rising Sun Cecil Co. Md.

18 (a) Funeral director Thomas Cook & Sykes
(b) Address 1605 W. North Ave

1947 SEP 27 1947 (b) Curtis Williams, M.D. Registrar
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1947, at 10A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1941, to 9/26 1947.
and that I last saw h. Ca alive on 9/26 1947.

Immediate cause of death Pulmonary Edema — Duration 2 mos.
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [illegible] M. D.
Address 30 [illegible] Date signed 9/27/47

G55476 Riggs 749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered G55476

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 5006 Curtis Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Riggs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-1-45

8. AGE: Years 2 | Months 3 | Days 27 | If less than one day ___ hr. ___ min.

9. Birthplace W. Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Ernest Riggs
13. Birthplace W. Va.

MOTHER 14. Maiden Name Lettie MacCrone
15. Birthplace Pa.

16 (a) Informant Dr
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-27-47 (month) (day) (year)
(c) Cemetery or crematory Oakhill
Location Salt Md

18 (a) Funeral director Lynch Crockett
(b) Address 900 Edmondson Ave

19 (a) SEP 27 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-25-1947, at 6.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-16-1947 to 9-25-1947 and that I last saw h[illegible]ive on 9-25-1947

Immediate cause of death Leukemia
Acute Lymphoblastic

Duration Known 9 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Neill Lyman M.D.
Address Johns Hopkins Hosp Date signed Sept 26 1947

X

G55477

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131A

Registered No. G55477

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1528 E Biddle St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1528 E. Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lucinda Maddox

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7 1865

8. AGE: Years	Months	Days	If less than one day
82	6	16	hr. min.

9. Birthplace Bels Md (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Mary Ellen?
15. Birthplace Md.

16 (a) Informant Alice Chappel
(b) Address 1528 E Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 25/47 (month) (day) (year)
(c) Cemetery or crematory Arbutus M. Park
Location Arbutus Md.

18 (a) Funeral director Mrs. Robt. A. Ellerson & Son
(b) Address 1297 N. Caroline St

19 (a) SEP 27 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23 1947, at 7 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 1947, to Sept 23 1947, and that I last saw h[illegible] alive on Sept 23 1947.

Immediate cause of death Uremia — Duration 2

Due to Chr. Cardio-vascular Renal Disease — Duration ?

Due to — Duration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. L. Berry M. D.
Address 420 E. Chase Date signed Sept 27 47

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55478

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 46 D

G55478 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1340 Fremont ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No 1340 Fremont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fannie Eppa (Valentine)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/14/1910

8. AGE: Years	Months	Days	If less than one day
37	8	11	hr. min.

9. Birthplace Balto - Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Jordan Eppa
13. Birthplace Richmond Va

MOTHER
14. Maiden Name Martha Standard
15. Birthplace Richmond, Va

16 (a) Informant Lillie M. Diggs
(b) Address 1340 Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/29/47 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Maryland

18 (a) Funeral director Geo. A. Gleaves
(b) Address 1383 Pressman St

19 (a) SEP 27 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/28 1947, at 3 P M

21. I certify that death occurred on the date above stated that I attended deceased from 8/20 1947, to 9/28 1947, and that I last saw h alive on 9/23/1947

Immediate cause of death Carcinoma of the Uterus & Metastasis

	Duration
	1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. A. Jackson M. D.
Address 600 N Arlington Ave Date signed 9/29/47

VS 150

G55479

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1489

Registered G55479

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1409 Patapsco St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1409 Patapsco St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maxine E. Moran

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Charles J. Moran
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): June 17 1913
8. AGE: Years 34 | Months 3 | Days 8 | If less than one day: hr. min.
9. Birthplace: Brunswick Md (Town, county, and state)
10. Usual Occupation: House Wife
11. Industry or business: at Home

FATHER
12. Name: Clark J. Keller
13. Birthplace: Brunswick Md

MOTHER
14. Maiden Name: Ethel V. Miller
15. Birthplace: Brunswick Md

16 (a) Informant: Mrs. Charles J. Moran
(b) Address: 1409 Patapsco St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 29/47 (month) (day) (year)
(c) Cemetery or crematory: Parkhurst Cemetery
Location: Brunswick Md

18 (a) Funeral director: Elmer McConkey & Son
(b) Address: 924 E. Eager St.

19 (a) SEP 27 1947 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25, 1947 at 8:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 17 to Sept 25 1947 and that I last saw her alive on Sept 23 1947.

Immediate cause of death	Duration
Carcinoma of	
Due to Cervix & Uterus	7 mos.
Due to	
Other Conditions Cachexia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Biopsy Cervix & Curettage 1947
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isaac Miller M. D.
Address 1125 Charles St. Date signed 9/26/47

V S 150

G55480

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131A

Registered No. G55480

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 818 S. Eaton St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 818 S. Eaton St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Arno B. Beyer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Lillian H. Peetz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4, 1889

8. AGE: Years	Months	Days	If less than one day
58	5	20	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Chef (Eastern Rest.)
11. Industry or business

FATHER
12. Name Louis Beyer
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Lang
15. Birthplace Germany

16 (a) Informant Wife
(b) Address 818 S. Eaton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) SEP 27 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24 1947 at 1:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21 1947 to Sept 24 1947, and that I last saw h. alive on Sept 24 1947.

Immediate cause of death	Duration
Acute Cardiac Failure.	
Due to Hypertensive Cardio-vascular - Renal Disease.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward A. Flanigan M.D.
Address 3503 Fait Ave. Date signed 9-25-47

X

G55481

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

G55481 Registered No.

MARGIN RESERVED FOR RUBBER STAMP. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2209 Belair Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2209 Belair Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Oriel Roberts

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Alice Roberts
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) 5/10/1877

8. AGE: Years	Months	Days	If less than one day
70	4	16?	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Oriel Roberts
13. Birthplace Maryland

MOTHER
14. Maiden Name Allie Wainwright
15. Birthplace Md.

16 (a) Informant Lois White
(b) Address 2209 Belair Rd.

17 (a) Interment (Burial, cremation, or removal) (b) Date thereof Sept 29, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Vernon Md.
Location Princess Anne, Md.

18 (a) Funeral director Dale Dashiell
(b) Address Princess Anne, Md.

19 (a) SEP 27 1947 (Date rec'd by registrar) (b) Beatrice Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/27/47 19 ; at 5:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/27 19 47 to 9/27/47, and that I last saw h. alive on 9/27 19 47

Immediate cause of death Coronary Occlusion — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. Baum M.D.
Address 1501 N. Milton Ave Date signed 9/27/47

For Dr. J. Fulmer Ross
Howard J. Wiedefeld, M.D.

G55482

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G55482

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2749 W. Lafayett Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 2749 W. Lafayette St. (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore, Md. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country NO

3 (a) FULL NAME Ella M. Motter

3 (b) If veteran, name war	3 (c) Social Security Account No.
***	***

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Edward G. Motter
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) July 19, 1865

8. AGE: Years	Months	Days	If less than one day
82	2	7	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Rosensteel
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Dukehardt
15. Birthplace Maryland

16 (a) Informant Edward G. Motter
(b) Address 2749 W. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/29/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 (a) SEP 27 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26 1947, at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1945 to Sept 26 1947. and that I last saw h[illegible] alive on Sept 24 1947.

Immediate cause of death Coronary thrombosis — Duration 30 minutes

Due to Arteriosclerotic type heart disease with hypertension and — Duration several years

Due to Congestive failure — Duration

Other Conditions Acute hypertension.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Michel, M.D.
Address 2901 Edmondson Ave. Date signed Sept 26 1947

VS 150

G55483

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 947

G55483 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d. o. a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 110 N. Stricker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harrison E. HELMICK

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 217-10-1721

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rose Helmick
6 (c) If alive, give age 26 years

7. Birth date of deceased (mo., day, yr.) April 11, 1912

8. AGE: Years 35 | Months 5 | Days 15 | If less than one day ____hr. ____min.

9. Birthplace W. Va. (Town, county, and state)
10. Usual Occupation Shipfitters Helper
11. Industry or business Ship Yard

FATHER
12. Name Arthur Helmick
13. Birthplace W. Va.

MOTHER
14. Maiden Name Sarah Blackburn
15. Birthplace W. Va.

16 (a) Informant Rose Helmick
(b) Address 110 N. Stricker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 30-1947 (month) (day) (year)
(c) Cemetery or crematory Fellowcraft Cem
Location Cumberland Md

18 (a) Funeral director Pratt & R. M. Walter
(b) Address Pratt & Stricker St

19 (a) SEP 27 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-26-1947, at 7 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 9/27/47

G55484

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

G55484 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State D.C. (b) County
(c) City or town Asheville (If outside city or town limits, write RURAL and give town)
(d) Street No. 1 Evelyn Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nina P. Gennett

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Nathaniel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-12-81

8. AGE: Years 65 | Months 10 | Days 15 | If less than one day hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Robert L. Carter
13. Birthplace Va

MOTHER
14. Maiden Name Mary F. Cunningham
15. Birthplace S.C.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/47 (month) (day) (year)
(c) Cemetery or crematory
Location Asheville, N.C.

18 (a) Funeral director John O. Mitchell Sons.
(b) Address 1900 Eastern Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27 1947 at 10 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 28 1947 to Sept 27 1947 and that I last saw her alive on Sept 27 1947.

	Duration
Immediate cause of death: Respiratory failure	acute
Due to: probable coronary Thrombosis or	acute
Due to: cerebro vascular accident	
Other Conditions: hydronephrosis, st	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature
Address Asheville Geneva Date signed 9-27-47 M. D.

VS 150

G55485

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G55485 Registered No. 186A

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4811 Kenwood ave. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Herman P. Smith, Sr.

3 (b) If veteran, name war /

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Margaret Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-6-21

8. AGE: Years	Months	Days	If less than one day
46	3	5	....hr. ....min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Operating Engineer

11. Industry or business Western Electric Co.

FATHER
12. Name Albert Smith
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Brill
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Herman P. Smith, Jr.
(b) Address 4811 Kenwood Ave. Balto. 6 Md.

17 (a) burial (b) Date thereof 9/29/47 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director Lansdale Funeral Home
(b) Address 7401 Belair Rd. Balto. 6, Md

19 (a) 9/28/47 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/26 1947, at 5 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Fractured skull & intracranial hemorrhage

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 26-6

(a) Date of injury 9/26/47 at 11:30 A.M.
(b) Where did injury occur? Western Electric Roof Ft. Briggs
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? yes
(d) Means of injury: Fell 15-20 ft. off a boiler

23. Signature Earl C. Logan M.D. (Medical Examiner.)

Date signed 9-27-47

G55486

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 9-B

G55486 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 847 Washington Blvd
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) — 21
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore — (If outside city or town limits, write RURAL and give town)
(d) Street No. 847 Washington Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ARVIDS GARAIS

3 (b) If veteran, name war: —
3 (c) Social Security Account No.:

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: ETHEL

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 21-1910

8. AGE: Years 36 | Months 9 | Days 16 | If less than one day hr. min.

9. Birthplace LATVIA (Town, county, and state)

10. Usual Occupation Sales mancer

11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mrs. Ethel Garais
(b) Address 847 Washington Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 29 47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Fredwick ave

18 (a) Funeral director Thos J. Kenny Inc
(b) Address 1600 HOLLINS Ave

19 (a) 9 29 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sep. 26 1947 at 7 05 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sep 12 1947 to Sep 26 1947 and that I last saw h[illegible] alive on Sep. 26 1947.

Immediate cause of death	Duration
Acute Cardiac Failure	
Due to Rheumatic Heart Disease with Mitral Stenosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Alfred Cole
Address 1934 Wilkins Ave. Date signed 9-26-47 M. D.

G55487

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G55487 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6701 Rosemont Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6701 Rosemont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma C. Bathurst

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Eli W. Bathurst
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3, 1856

8. AGE: Years	Months	Days	If less than one day
91	5	23	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Miller
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Mary Golden
15. Birthplace Pennsylvania

16 (a) Informant Joseph H. Bathurst
(b) Address 801 W. 15th St. Tyrone, Pa.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-27-47 (month) (day) (year)
(c) Cemetery or crematory Graysville
Location Tyrone, Pa.

18 (a) Funeral director Wm. Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26 1947 at 10:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/20 1946 to 9/26 1947, and that I last saw h-er alive on 8/25 1947.

Immediate cause of death	Duration
Myocardial Degeneration	10 Years
Due to Arteriosclerosis	10 Yrs +
Due to	
Other Conditions Senility	10 Yrs +

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operations: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address 6331 Belair Rd. Date signed 9/27/47 M. D.

VS 150

G55488

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G55488 Registered No.

CERTIFICATE OF DEATH 47D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital, Balto., Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 16 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Glass
(If outside city or town limits, write RURAL and give town)
(d) Street No. - (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME
Christopher Columbus Conway, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 223-26-0321

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Cora Smith Conway
6 (c) If alive, give age -? years

7. Birth date of deceased (mo., day, yr.) March 1, 1888

8. AGE: Years	Months	Days	If less than one day
59	6	26	....hr. ....min.

9. Birthplace Gloucester Co., Virginia
(Town, county, and state)
10. Usual Occupation Captain
11. Industry or business Seafarer

FATHER
12. Name Eli Conway
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Sallie Wast
15. Birthplace ?, Va.

16 (a) Informant Records
(b) Address U. S. Marine Hospital

17 (a) Burial (b) Date thereof Sept 30-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Ebenezer
Location Gloucester Va.
18 (a) Funeral director Ellsworth Funeral
(b) Address 3911 Liberty Heights Ave
19 (a) ..... (b) .....
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27 19 47, at 6:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 11 19 47 to Sept. 27 19 47 and that I last saw him alive on Sept. 27 19 47

Immediate cause of death	Duration
Carcinoma of right lung with generalized visceral metastases	Unknown
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surg. Clinical Dir.
Address U. S. Marine Hospital, Balto., Md. Date signed 9/27/47

V S 150

G55489 BALTIMORE CITY HEALTH DEPARTMENT X ✓ G55489
Registered No.

CERTIFICATE OF DEATH 186A

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave. and Madison St.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND County BALTIMORE
(c) City or town WHITE HALL (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE COLLETT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	SINGLE

6 (b) Name of husband or wife NONE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) UNKNOWN 1867

8. AGE: Years	Months	Days	If less than one day
80 (APPROX)			hr. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name Howard Collett
13. Birthplace White Hall, Md

MOTHER
14. Maiden Name —
15. Birthplace

16 (a) Informant Howard Collett
(b) Address White Hall, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 30-47 (month) (day) (year)
(c) Cemetery or crematory Wiseburg
Location White Hall, Md

18 (a) Funeral director Howard S. Mackenzie
(b) Address White Hall Md

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/27 1947, at 9:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/25 1947, to 9/27 1947, and that I last saw her alive on 9/27 1947.

Immediate cause of death UREMIA — Duration

Due to CARDIAC FAILURE, RENAL INSUFFICIENCY

Due to SENILITY

FRACTURE OF LEFT FEMUR (NECK

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ACCIDENT 53-00
(b) Date of occurrence ~~9/18~~ 9/18/47 at 10:30 A.M.
(c) Where did injury occur? WHITE HALL (City or town) MD (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? HOME (Specify type of place) While at work? NO
(e) Means of injury Fell while rising from chair

23. Signature Paul G. Herold M. D.
Address Maryland General Hosp. Date signed 9/27/47

VS 180 To be approved by medical examiner for O'Brien Holland Howard J. Malone, M.D.

G55490

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G55490

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument & Rutland Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3426 Virginia Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nathan Siegel

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-6259

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Leah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation
11. Industry or business Salesman

FATHER
12. Name Isaac Siegel
13. Birthplace Russia

MOTHER
14. Maiden Name Fannie Finestein
15. Birthplace Russia

16 (a) Informant Leah Siegel
(b) Address 3426 Virginia Ave

17 (a) Burial (b) Date thereof Sept 28, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

SEP 29 1947 (a) Registered (b) Lillington Williams Registrar

VS 150

MEDICAL CERTIFICATION 310

20. DATE OF DEATH Sept 27 1947 at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/24 1947 to 9/27 1947
and that I last saw h alive on 9/27 1947

Immediate cause of death Cardiac failure — Duration

Due to Coronary Thrombosis

Due to Arteriosclerotic heart disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irving Rosen M. D.
Address Sinai Hospital Date signed 9-27-47

AdCo. 5-11 2508

12-4B ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

G55491

G55491

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registered No.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3604 Garrison Blvd St., ... Ward)

Length of residence in city or town where death occurred 67 yrs. 5 mos. 14 ds. How long in U.S. If of foreign birth? ....yrs. ....mos. ....da.

2. FULL NAME Mrs. Ida Julia Shelley

(a) Residence: No. 3604 Garrison Blvd St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4 Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Divorced

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of William Sheeley

6. DATE OF BIRTH (month, day, year) April 13 1880

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
67	5	14	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Cashier

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Biabta Motion Pictures

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore Maryland

FATHER

13. NAME John Henry Bierman

14. BIRTHPLACE (city or town) (State or country) Holland

MOTHER

15. MAIDEN NAME Louise Augusta Letmate

16. BIRTHPLACE (city or town) (State or country) Baltimore Maryland

17. INFORMANT Mrs Fred. S Mueller

(Address) 408 N Holly St

18. BURIAL, CREMATION, OR REMOVAL St Pauls Cemetery Sept 30 1947

19. UNDERTAKER Wm Chas E G Rehdel

(Address) 3327 Edmondson Ave

Huntington Williams, M.D.
Registrar.

FILED SEP 28 1947

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Sept. 27, 1947

22. I HEREBY CERTIFY, That I attended deceased from August 4, 1947, to Sept. 27, 1947

I last saw her alive on Sept. 27, 1947, death is said to have occurred on the date stated above, at 4 P. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Massive Hemorrhage	Sept 27/47
Cardiac Failure	Sept 27/47

Other contributory causes of importance:

Ruptured Esophageal Varices	Aug. 4/47
Cirrhosis of Liver; Secondary Anemia	
Terminal Pneumonia	

Name of operation..... Date of.....

What test confirmed diagnosis? Clin. Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide?.....Date of injury....., 19....

Where did injury occur?.....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No If so, specify .....

(Signed) Reynolds Lenson-Lawlor M. D.

(Address) 1224 Bloomingdale Road

N. B.—Name of informant should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55492

BALTIMORE CITY HEALTH DEPARTMENT ✓ G55492
CERTIFICATE OF DEATH 45 F
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green Spring & Belvedere Ave
(c) Hospital or institution:
Levindale
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 35 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town) 3
(d) Street No. 2103 E. Fairmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BENJAMIN FRIEDMAN

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Esther

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1895

8. AGE: Years 52 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Mrs. Esther Friedman
(b) Address 2103 E. Fairmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-28-47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Sinai A.R.
Location Windsor Mill Rd

18 (a) Funeral director Jack Levin Inc
(b) Address 2100-02 Eutaw Place

19 (a) SEP 29 1947 (Date received by registrar) Washington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-27 1947 at 11 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 14 1947 to 9-27 1947 and that I last saw h[illegible] alive on 9-27 1947

Immediate cause of death Carcinoma of oropharynx — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Nagel M. D.
Address Levindale Home Date signed 9-27-47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55493

BALTIMORE CITY HEALTH DEPARTMENT ✓ G55493

CERTIFICATE OF DEATH 83A

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [illegible]
(c) Hospital or institution: Sinai Hospital. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3015 Garrison Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH BERMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	White	Married

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
72	—	—	hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Real Estate

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Anna Barman
(b) Address 3015 Garrison Boul

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-28-47 (month) (day) (year)
(c) Cemetery or crematory
Location Hebrew Friendship

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) 9-27-47 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1947, at 11.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 26 1947 to Sept 27 1947, and that I last saw him alive on Sept 27 1947

Immediate cause of death Cerebral Hemorrhage. — Duration 2 days.

Due to Hypertension.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Oscar Kaufman, M. D.

Address Sinai Hospital Date signed 9/27/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55494 ✓

G55494

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 930

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 108 No Melton Ave
(c) Hospital or institution: 6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 No Melton ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Liba Manner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Solomon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Moses
13. Birthplace Russia

MOTHER
14. Maiden Name Faga
15. Birthplace Russia

16 (a) Informant Solomon Manner
(b) Address 108 No Melton ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-28-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philad Rd + Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2400 Eastern Place

19 (a) (Date rec'd by registrar) (b) Registrar

VS 189

SEP 28 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1947, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to Sept 27 1947, and that I last saw h alive on Sept 27 1947.

Immediate cause of death: General Arteriosclerosis — Duration 3 yrs
Due to: Chronic Myocarditis — 3 yrs
Due to: Coronary Thrombosis — 2 hrs
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Melton L. Solomon M. D.
Address 119 S. Bway Date signed 9/29/47

G55495 BALTIMORE CITY HEALTH DEPARTMENT G55495
Registration No.

CERTIFICATE OF DEATH 164-A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4508 Schenley Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4508 Schenley Road
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Chauncey Edward Bortner

3 (b) If veteran, name war: World War #2
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19-1901

8. AGE: Years	Months	Days	If less than one day
46	6	7	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name John M. Bortner
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Jane Stockdale
15. Birthplace Maryland

16 (a) Informant Claude Earl Bortner
(b) Address 4508 Schenley Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 29-1947 (month) (day) (year)
(c) Cemetery or crematory St Pauls
Location Arcadia Balto. Co. Md

18 (a) Funeral director Burgee Funeral Home
(b) Address 3621 Falls Road

SEP 28 1947 (Date rec'd by registrar) (b) Hunter for Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-26 1947, at 1½ P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH asphyxiation

Due to hanging

Other Conditions Deformity.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 27-14
(a) Date of injury 9/26/47 at abt. 1 P. M.
(b) Where did injury occur? 4508 Schenley Rd
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Hanging by rope from rafter

23. Signature Harold J. Mueller M.D.
Medical Examiner.
Date signed 9-26-47

G55496

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163B

G55496

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 24
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 9 Mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. South Balto. Gen. Hosp.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Mary Horwath or HORVATH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1, 1910

8. AGE: Years	Months	Days	If less than one day
37	6	25	hr. min.

9. Birthplace Bethlehem, Pa.
(Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business So. Balto. Gen. Hosp.

FATHER
12. Name Julius
13. Birthplace Hungary

MOTHER
14. Maiden Name Mary Braza
15. Birthplace Unknown

16 (a) Informant Marvin M. Steyer
(b) Address Bethlehem, Pa.

17 (a) Removal (b) Date thereof 9/28/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Savior
Location Bethlehem, Pa.

18 (a) Funeral director Harry H. Leitzke
(b) Address 410 Elm Huntingdon Pa.

9 28 1947
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26 1947, at 1:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Barbiturate Poisoning (Nembutal)

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-26-47 at A.M.
(b) Where did injury occur? So. Balto. Gen. Hosp.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Ingesting Seconal Tablets

23. Signature [signature] M.D.
Medical Examiner.
Date signed 9-27-47

G55497 BALTIMORE CITY HEALTH DEPARTMENT G55497
B# D90297 CERTIFICATE OF DEATH 161A Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Franklin Square Hosp.
(c) Hospital or institution:
Fayette & Calhoun Sts.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 9 hr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore.
(c) City or town Catonsville. 29
(If outside city or town limits, write RURAL and give town)
(d) Street No. 747 Charing Cross Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Esmond.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: W

6 (a) Single, married, widowed, or divorced. New Born.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-27-47

8. AGE: Years | Months | Days | If less than one day: 9 hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation New Born

11. Industry or business —

FATHER
12. Name William George Esmond
13. Birthplace Stratford, Conn.

MOTHER
14. Maiden Name Ella Marie Weaver.
15. Birthplace Akron, Ohio.

16 (a) Informant Ella Esmond.
(b) Address 747 Charing Cross Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-28-47 (month) (day) (year)

(c) Cemetery or crematory St. Johns
Location Ellicott City, Md.

18 (a) Funeral director George L. Farley
(b) Address Fulton Ave & Fayette St.

19 (a) [illegible] Huntington Williams, M.D.
(Date received by registrar) Registrar

SEP 28 '47

VS 150

MEDICAL CERTIFICATION 20

20. DATE OF DEATH Sept. 27 1947, at 10 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 26 1947, to Sept. 27 1947, and that I last saw her alive on Sept 27 1947.

Immediate cause of death: Congenital atelectasis — Duration: 9 hrs.

Due to

Due to

Other Conditions: none

(Include pregnancy within 3 months of death)

Date of operation: none

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gordon B. Bidoung M. D.

Address Franklin Square Hosp. Date signed 9/27/47

X

C55498 MD

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 93D

C55498 Registered No.

MARGIN 15 mm. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2819 Hampden Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLARENCE WHEELER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Aquilla Wheeler
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Porter
15. Birthplace Md.

16 (a) Informant Annie L. Belt
(b) Address 1024 Union Ave

17 (a) Burial (b) Date thereof 9/30/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ St. Marys-Hampden
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) SEP 29 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26, 1947, at 9.25 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic myocardial degeneration

Due to

Other Conditions Acute alcoholism

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner.
Date signed 9-26-47

G55499

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 50

G55499
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 853 Park Ave,
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 853 Park Ave,
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Grayce L. Horn

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed or divorced: Married

6 (b) Name of husband or wife: Samuel J. Horn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 30, 1898

8. AGE: Years 48 49 | Months 10 | Days 26 | If less than one day hr. min.

9. Birthplace Illinois
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Rice
13. Birthplace New York

MOTHER
14. Maiden Name Julia Sweeney
15. Birthplace Pennsylvania

16 (a) Informant Samuel F. Horn
(b) Address 853 Park Ave

17 (a) Removal (b) Date thereof 10/1/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Belvidere
Location Belvidere Md

18 (a) Funeral director Fallon & Son
(b) Address 2174 Pond St

SEP 29 1947 (b) Huntingtown Williams, Md
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27 1947, at 1:53 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 11 1947 to Sept 27 1947 and that I last saw h[illegible] alive on Sept 27 1947.

Immediate cause of death	Duration
Respiratory Failure	
Due to Carcinoma of Lungs	
Due to Metastasis from Breast Carcinoma	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Clarence E. McWilliams Jr
Address Mercy Hospital Date signed 9-27-47

VS 150

G55500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G55500

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Ballona Ave.
(c) Hospital or institution:
Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County BALTO.
(c) City or town Essex, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. Philadelphia Rd. & Golden Ring (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AMELIA VOLZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Joseph H. Volz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 3rd, 1865

8. AGE: Years	Months	Days	If less than one day
82	1	25	hr. min.

9. Birthplace Baltimore County, Md. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Wm. Fisher
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Altried
15. Birthplace Germany

16 (a) Informant Mr. Charles Volz
(b) Address Philadelphia Rd.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 9/30/47 (month) (day) (year)
(c) Cemetery or crematory Zion Lutheran
Location Stemmers Run, Md.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Rd.

19 (a) SEP 30 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28th 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1944 to 9/28 1947, and that I last saw h e alive on 9/25/1947.

Immediate cause of death	Duration
Cardiac failure	3 mo
Due to hypertensive degeneration	3 yrs.
Due to arteriosclerosis	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lawrence M. Serra
Address 11 E. Chase St Date signed 9/29/47 M. D.

Lawrence M. Serra

G55501 Colley

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G55501 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5011 Arabia Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5011 Arabia Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Wohlgemuth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1861

8. AGE: Years	Months	Days	If less than one day
85	10	2	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Christian Wohlgemuth
13. Birthplace ?

MOTHER
14. Maiden Name Katherine Deibel
15. Birthplace ?

16 (a) Informant Mrs. Jennie E. Bauernschmidt
(b) Address 5011 Arabia Avenue 14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-30-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) SEP 29 1947 (Date rec'd by registrar) Washington Williams (Registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/ /1947 to 9/27/1947 and that I last saw h alive on 19

Immediate cause of death Hypertensive Cardiac Vascular Disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Theodore Bailey M. D.
Address 5103 Johns Hopkins Hospital 9-29-47

G55502 Gordy

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G55502

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5882 Belair Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5882 Belair Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Ringrose

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife George J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5, 1873

8. AGE: Years	Months	Days	If less than one day
74	--	22	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15 Birthplace ?

16 (a) Informant Mrs. Vincent Arrigo
(b) Address 5882 Belair Road, 6
17 (a) Burial (b) Date thereof 9-29-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Baltimore, Md.
18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14
19 SEP 29 1947 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25, 1947, at 10 P. M

21. I certify that death occurred on the date above stated; that attended deceased from Sept 30 1943 to Sept 25 1947 and that I last saw h[illegible] alive on Sept 26 1947

Immediate cause of death Carcinoma of Uterus — Duration 4 1/2 years

Due to

Due to

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation Dec. 1943

Major findings of operation: Panhysterectomy

of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence None at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. L. Gordy M.D.
Address 5106 Harford Rd Date signed 9/26/47

C55503 — BALTIMORE CITY HEALTH DEPARTMENT — C55503

CERTIFICATE OF DEATH

Registered No. C55503

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga St
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) one day
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2819 Gardenwood Rd. (If rural give location)
(e) Citizen of foreign country? [redacted] No (Yes or No)
If yes, name country

3 (a) FULL NAME Jesse Raymond Wilbur
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Married

6 (b) Name of husband or wife (Clara) C. Wilbur
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Dec. 29, 1871

8. AGE: Years	Months	Days	If less than one day
75	9	28	hr. min.

9. Birthplace Westfairview, Penna. (Town, county, and state)
10. Usual Occupation Master Carpenter (Offices)
11. Industry or business Penna R. R.

FATHER
12. Name Josiah Pratt Wilbur
13. Birthplace Penna. Baltimore

MOTHER
14. Maiden Name Elizabeth Rodney
15. Birthplace Penna.

16 (a) Informant Clara (Clara) C. Wilbur
(b) Address 2819 Gardenwood Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-30-47 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Balto.

18 (a) Funeral director L. J. Luck
(b) Address 5305 Harford Rd.

19 (a) REC'D 9 30 1947 (Date rec'd by Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-26 1947 at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-26 1947 to 9-26 1947 and that I last saw him alive on 9-26 1947

Immediate cause of death: Cardiac Decomp. — Duration 24 hrs.
Due to: Coronary Infarction — 4 hrs.
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature Joseph Li Buti M. D.
Address Mercy Hosp Date signed 9-26-47

G55504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G55504

Every item of information should be carefully supplied. Type or write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Even correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1337 N. Gilmor st.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1337 N. Gilmor
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Chapman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	married

6 (b) Name of husband or wife Pearlie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 1, 1906

8. AGE: Years	Months	Days	If less than one day
41	6	26	hr. min.

9. Birthplace North Carolina
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Joseph Chapman
13. Birthplace North Carolina

MOTHER
14. Maiden Name Eugenia King
15. Birthplace North Carolina

16 (a) Informant Pearlie Chapman
(b) Address 1337 N. Gilmore St.

17 (a) Burial (b) Date thereof Sep 30 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Avenue

19 (a) SEP 29 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-27- 1947 at 8 45 A.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Alcoholism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George B. Merrill M.D.
Medical Examiner.

Date signed 9/27/47

G55505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G55505
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution:
So. Balti. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1da
(e) Length of stay in Baltimore (yrs., mos., or days) 1da

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3420 Toone Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Folck

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/27/47

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Glen Folck
13. Birthplace Montana

MOTHER
14. Maiden Name Margaret Klingenhoefer
15. Birthplace Md.

16 (a) Informant Glenn Folck (Father)
(b) Address 3420 Toone St.

17 (a) Burial (b) Date thereof 9-29-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem
Location Georgia Hill Rd.

18 (a) Funeral director Charles L. Zeller
(b) Address 901 S. Conkling St.

19 (a) [illegible] (b) [illegible]
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/28/1947 at 1 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/27 1947 to 9/28 1947 and that I last saw h[illegible] alive on 9/28 1947

Immediate cause of death	Duration
Respiratory Failure	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. D. Cooper M.D.
Address 1211 S. Light St. Date signed 9/29/47

G55506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131A

G55506 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1704 Dittman Ct.
(c) Hospital or institution:
16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 Dittman Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Betsie Ross

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1892

8. AGE: Years	Months	Days	If less than one day
55	2	2	hr. min.

9. Birthplace King & Queen Co. Va. (Town, county, and state)
10. Usual Occupation Laundress
11. Industry or business

FATHER
12. Name Murray Roberts
13. Birthplace Va.

MOTHER
14. Maiden Name Esther Williams
15. Birthplace Va.

16 (a) Informant Edward L. Ross
(b) Address 1704 Dittman Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-29-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Maryland
18 (a) Funeral director Nathan A. Jackson
(b) Address 916 Penna. Ave.
19 (a) SEP 29 1947 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25, 1947, at 3:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/16 1947 to 9/25 1947 and that I last saw h[illegible] alive on 9/16 1947.

Immediate cause of death Pulmonary Edema — Duration
Due to Hypertensive C.V. Renal Disease — 3 yrs. (Est.)
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Preston Grant M.D.
Address 1514 Division St Date signed 9/27/47

VS 150

G55507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47 D

G55507
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2303 Aiken St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2303 Aiken St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert E. Kratz

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary H Kratz
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Aug 14, 1887

8. AGE: Years	Months	Days	If less than one day
60	1	14	..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Garage Business
11. Industry or business

FATHER
12. Name Frederick Kratz
13. Birthplace Baltimore

MOTHER
14. Maiden Name Louise Hammerbacher
15. Birthplace Baltimore

16 (a) Informant Mrs Mary Kratz
(b) Address 2303 Aiken St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 30 1947 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) ..... (b) Huntington Williams M.D. (Date received by Registrar) Registrar

S.S.I. Form 450-A

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28 1947, at 5 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 4 1947, to Sept 29 1947, and that I last saw h alive on Sept 28 1947

Immediate cause of death	Duration
Carcinoma of the Lung	9 Mos.
Due to	
Due to	
Other Conditions Paralysis left side	
Cerebral Hemorrhage	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jacob Frahm
Address 1827 N Wash St Date signed 9/29/47 M. D.

G55508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G55508

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5609 Fairoaks Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days) 64yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 5609 Fairoaks Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Riess

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Dorothea Riess

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 4 1863

8. AGE: Years 84 | Months 8 | Days 23 | If less than one day ... hr. ... min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Brewer

11. Industry or business Retired

FATHER
12. Name Dont Know
13. Birthplace Germany

MOTHER
14. Maiden Name Dont Know
15. Birthplace Germany

16 (a) Informant Mrs Geo Biss

(b) Address 5609 Fairoaks ave

17 (a) Burial (b) Date thereof Sept 30th 47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location City

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2005 Orleans St.

19 (a) ... (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

V5 135

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1947, at 12 noon

21. I certify that death occurred on the date above stated; that I attended deceased from August 1947 to 9/27 1947 and that I last saw him alive on 9/27 1947

Immediate cause of death	Duration
Carcinoma of Stomach	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ... at ... M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Hyman I. Pollack M. D.

Address 5703 Harford Rd Date signed 9/27/47

X

G55509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94B

G55509
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 136 Jackson Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write Rural and give town)
(d) Street No. 136 Jackson Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Westly Kelley

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-46-6705

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Myrtle Kelley

6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) Aug 5-1893

8. AGE: Years 54 | Months 1 | Days 22 | If less than one day ____ hr. ____ min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business Painter

FATHER
12. Name Charles Kelley
13. Birthplace Md

MOTHER
14. Maiden Name Grace Scott
15. Birthplace Md

16 (a) Informant Myrtle Kelley
(b) Address 1225 N Linwood ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 1-1947 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) 30 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1947, at 4:15 P.M.

21. I certify that I took charge of the remains described above, held an Aug Ext Insp thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J Ulrich M.D.
Medical Examiner.
Date signed Sept 29, 1947

G55510

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83D

Registered No. G55510

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4002 Chatham Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4002 Chatham Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary R. Slade

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Walter R. Slade
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 9 1864

8. AGE: Years 83 | Months 78 | Days 17 | If less than one day hr. min.

9. Birthplace Penna
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Samuel H. Martin
13. Birthplace Penna.

MOTHER
14. Maiden Name Elizabeth Killgore
15. Birthplace Penna.

16 (a) Informant Rev Arthur C. Slade
(b) Address 4002 Chatham Rd

17 (a) Burial (b) Date thereof Sept 30, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Ignatius
Location Hartford Co.

18 (a) Funeral director John A. Marian
(b) Address 3400 E. Baltimore St.

19 (a) SEP 29 1947 (b)
(Date received by registrar)

A-47 5-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26 1947, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21 1947 to Sept 26 1947, and that I last saw h[illegible] alive on Sept 27 1947.

Immediate cause of death	Duration
Hemiplegia (Rt. Side)	5 days
Due to Arterio Sclerosis	4 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Michael A. Abrams M. D.
Address 1800 Eutaw Place Date signed Sept 27, 1947

X

G55511 436901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V81A

G55511 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1710 Alicanne, St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country (FRANK CORBETT)

3 (a) FULL NAME Victor Geyko or WILKTOR GUDEJKO -

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-01-4836

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife ?

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 1898 Not known ?

8. AGE: Years	Months	Days	If less than one day
49 ?			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name ?
13. Birthplace Poland ?

MOTHER
14. Maiden Name ?
15. Birthplace Poland ?

16 (a) Informant ?
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 29-47 (month) (day) (year)
(c) Cemetery or crematory Holy Trinity Russian
Location Stoney Run Md

18 (a) Funeral director John A Grebliunkas Jr
(b) Address 423 S. Paca St.

SEP 29 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 - 1947, at 11 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-24-1947 to 9-26 1947. and that I last saw him alive on 9-26- 1947.

Immediate cause of death	Duration
Meningitis	
Due to ? Pneumococcus ? Typ.	3½ hours
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis H. Gault
Address X Date signed 9-29-47

G55512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

G55512 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 617 Rosedale St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 617 Rosedale St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Butler

3 (b) If veteran, name war

3 (c) Social Security Account No. 3

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband~~ or wife: Elizabeth K. Butler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 11-1881

8. AGE: Years 65 | Months 11 | Days 18 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Master Plumber

11. Industry or business -

FATHER
12. Name Geo. W. Butler
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Ida Dodson
15. Birthplace Balto. Md

16 (a) Informant Mrs. Elizabeth K. Butler
(b) Address 617 Rosedale St -16

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 1- (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Edmondson ave

18 (a) Funeral director McCully Funeral Home
(b) Address 130 E Fort ave

1947 SEP 29 (Date received by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1947, at 5.15A M

21. I certify that death occurred on the date above stated; that I attended deceased from Decemb 1945 to Sept 30 1947, and that I last saw h~~im~~ alive on Sept 29 1947.

Immediate cause of death Cerebral Haemorrhage + Hemiplagia — Duration 3 days

Due to Arteriosclerosis with Hypertension — Duration several years

Due to

Other Conditions Arteriosclerotic type, heart disease with Hypertrophy
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Michel M. D.

Address 2901 Edmondson Date signed Sept 30 1947

83 A

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1540

Registered No. G55513

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: ST JOSEPH'S HOSP
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1706 S. CHARLES ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VOLL, CHARLES

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-01-5783

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	Widowed

6 (b) Name of husband or wife. Mary E. Voll

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/29/84

8. AGE: Years	Months	Days	If less than one day
63	1	28	hr. min.

9. Birthplace BALTO, MD (Town, county, and state)

10. Usual Occupation MAINTENANCE

11. Industry or business STANDARD OIL PRINTING DEPT

FATHER
12. Name John Voll
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Ahern
15. Birthplace Baltimore

16 (a) Informant Mrs Edward Williams
(b) Address 1706 S. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 1, 1947 (month) (day) (year)

(c) Cemetery or crematory Holy Cross
Location Baltimore Highway Md.

18 (a) Funeral director McCully Funeral Home
(b) Address 130 E. Ost Ave.

19 SEP 29 1947 (Date rec'd by registrar) (Signature) Hunting Fox Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/27 1947, at 5 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/29 1947 to 9/27 1947 and that I last saw him alive on 9/27 1947.

Immediate cause of death	Duration
TOXEMIA	
Due to CHRONIC OSTEOMYELITIS	
Due to INFECTED OSTEOPOROSIS	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: AUTO

of autopsy OSTEOPOROSIS, INFECTED, FEMUR

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry R Porter

Address St Joseph Hosp Date signed 9/28/47

G55514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

BC# 989719 ✓ 157H

G55514 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Balto. 31 Md.
(c) Hospital or institution: CHURCH HOME HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day.

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County 3227 Mt Elderson
(c) City or town Baltimore 31
(If outside city or town limits, write RURAL and give town)
(d) Street No. CHURCH HOME HOSPITAL
(If rural give location)
(e) Citizen of foreign country? N.A.G. (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Moore

3 (b) If veteran, name war

(c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-25-47

8. AGE: Years	Months	Days	If less than one day
0	0	1	hr. min.

9. Birthplace Church Home Hosp. (Town, county, and state)

10. Usual Occupation infant

11. Industry or business

FATHER
12. Name Bradley Moore
13. Birthplace Md.

MOTHER
14. Maiden Name Thelma Glass
15. Birthplace Md.

16 (a) Informant Parents
(b) Address 3227 Mt Elderry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-29-47 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Edgerton Rd
18 (a) Funeral director John J. Connolly
(b) Address 4 W Eastern Ave E.

SEP 29 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 Sept. 1947, at 5 00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 25 Sept. 1947 to 26 Sept. 1947, and that I last saw him alive on 26 Sept 1947

Immediate cause of death: Intrauterine asphyxia — Duration:
Due to: Torsion of umbilical cord
Due to: Varicosities of umbilical cord
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation: congenital umbilical deformation with bilateral varicosities of cord
Autopsy? Syndrome phrase

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. Fisher M. D.
Address Church Home Date signed 9-27-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

G55515
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison + Linden
(c) Hospital or institution: Md. Gen'l. Hospital 9th
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 da
(e) Length of stay in Baltimore (yrs., mos., or days) 8 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1250 Clifton Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country Baltimore

3 (a) FULL NAME Wilson Chesley Dunn

3 (b) If veteran, name war

3 (c) Social Security Account No. 515-07-9073

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Doris M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1906

8. AGE: Years	Months	Days	If less than one day
41	4	18	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Construction Foreman
11. Industry or business Consolidated Eng. Co.

FATHER
12. Name Harvey C. Dunn
13. Birthplace Va

MOTHER
14. Maiden Name Mary Etta Eubanks
15. Birthplace Va.

16 (a) Informant Mrs Doris Dunn
(b) Address 1250 Clifton ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept 29/47 (month) (day) (year)
(c) Cemetery or crematory
Location Union Level Va.

18 (a) Funeral director Harry H. Wittstadt
(b) Address 1110 E Lanvale St.

19 SEP 29 1947 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 1947 at 4:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 12 1947 to Sept. 25 1947, and that I last saw him alive on Sept. 25 1947

Immediate cause of death Circulatory Failure — Duration
Due to Chronic Myocarditis
Due to
Other Conditions Biliary Cirrhosis
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy 9-25-47

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William V. Schulte M. D.
Address Md. Gen'l Hosp Date signed 9-25-47

93D

G55516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170 C

G55516 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen'l
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Gambrill's (If outside city or town limits, write RURAL and give town)
(d) Street No. Fort Meade R.D. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William D. Osborne Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-26-1423

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11, 1929

8. AGE: Years	Months	Days	If less than one day
18	3	17	hr. min.

9. Birthplace Damascus - Washington Co. Va. (Town, county, and state)
10. Usual Occupation Operator
11. Industry or business National Plastic Co.

FATHER
12. Name William David Osborne Sr.
13. Birthplace Toms Creek, Va.

MOTHER
14. Maiden Name Callie Elizabeth Neeves
15. Birthplace Glade Spring, Va.

16 (a) Informant Mrs. Wm. David Osborne Sr.
(b) Address Gambrils, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 30, 1947 (month) (day) (year)
(c) Cemetery or crematory Damascus Cemetery
Location Damascus, Virginia

18 (a) Funeral director Thomas B. Singleton
(b) Address Glen Burnie Md.

1947 SEP 29 (Date received by registrar) Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-28 1947 at 3:15 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture of skull & contusion of brain -

Due to

Other Conditions Fracture comminuted left tibia & fibula -
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9/21/47 at 5:35 A.M. $2.00
(b) Where did injury occur? Crane Highway + 5 Aor
(c) Did injury occur at home, on farm, industrial place, in public place? public place While at work? no
(d) Means of injury Pedes. struck by auto

23. Signature Lowell L. Engle M.D. (Medical Examiner.)
Date signed 9-29-47

G55517

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1947

G55517
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1821 Md Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1821 Maryland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William B. Jones

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	M

6 (b) Name of husband or wife Fannie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/16/1879

8. AGE: Years	Months	Days	If less than one day
68	4	8	hr. min.

9. Birthplace: Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Henry Jones
13. Birthplace Md

MOTHER
14. Maiden Name Chaflott
15. Birthplace Md

16 (a) Informant Fannie Jones
(b) Address 1821 Maryland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/39/47 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Md

18 (a) Funeral director Wm. H. Nelson
(b) Address 1363 Presstman St

SEP 29 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 Sept 1947, at 5:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1 July 1947 to 10 Sept 1947, and that I last saw h[illegible] alive on 11 Sept 1947.

Immediate cause of death: Coronary Occlusion — Duration

Due to: Hypertension

Due to: Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Blue R Coates Jr. M.D.
Address 2139 Eyrl Hill Date signed 26 Sept 47

G55518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G55518 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyoming Park Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4637 Kernwood Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Bridgett Lyng

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1901

8. AGE: Years	Months	Days	If less than one day
45	10	6	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Machine Operator
11. Industry or business Continental Can Co.-Balto.

FATHER
12. Name Thomas Lyng
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary ?
15. Birthplace Ireland

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-29-47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location City

18 (a) Funeral director Wiedefeld & Son
(b) Address Greenmount Ave & 22nd

19 (a) 9-29-1947 (Date filed by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26 1947, at 2:45A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 19 1947 to Sept. 26 1947, and that I last saw her alive on Sept. 26 1947.

Immediate cause of death	Duration
(1) Myocardial infaraction	few days
(2) Adenocarcinoma left breast, with metastasis to skin, pleura, lungs, rib and right breast	more than 5 mos.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon
Address Clinical Director Date signed 9/26/47

V S 150

G55519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G55519
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1009 S. Patterson
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Elsie Macb

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife James G. Macb

6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) 2-7-03

8. AGE: Years 44 | Months 7 | Days 19 | If less than one day: hr. min.

9. Birthplace Balto - Md
(Town, county, and state)

10. Usual Occupation H W

11. Industry or business

FATHER
12. Name James Rasinski
13. Birthplace Poland

MOTHER
14. Maiden Name Eva
15. Birthplace Poland

16 (a) Informant Husband
(b) Address 1009 S Potomac

17 (a) B (Burial, cremation, or removal) (b) Date thereof 9-30-47 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Dundalk ave

18 (a) Funeral director John J Wuda
(b) Address 2829 Eastern ave

19 (a) (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-26-1947 11:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-26 1947 to 9-26 1947, and that I last saw h. alive on 9-25 1947.

Immediate cause of death Atelectasis
+ Myocardial Failure — Duration

Due to Ca of Lung Metast to Syn

Due to Ca of Breast

Other Conditions Hypertension
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Date signed 9-27-47

X

25 1947 150

G55520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

G55520 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4510 mansfield ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4510 Mansfield Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mary Elizabeth Henkelman

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	MARRIED

6 (b) Name of husband or wife Edgar Henkelman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7-1887

8. AGE: Years	Months	Days	If less than one day
60	2	20	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Robert M. Thorsel
13. Birthplace Germany

MOTHER
14. Maiden Name Marie Sanders
15. Birthplace Germany

16 (a) Informant Edgar Henkelman
(b) Address 4510 Mansfield ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 30-1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location Balto. md

18 (a) Funeral director A. Reiley Slade
(b) Address 49 W Lexington St Baltimore, Md

19 (a) Sept 29 1947 (b) (Local registrar) Registrar

VS 3

MEDICAL CERTIFICATION 30

20. DATE OF DEATH Sept 27 1947 at 1 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 24 1947 to Sept 27 1947 and that I last saw h.e.r alive on Sept 26 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertensive Cardio-Vascular disease.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. Brennan M. D.
Address 5217 Harford Rd Date signed 9-29-47

G55521 BALTIMORE CITY HEALTH DEPARTMENT G55521

CERTIFICATE OF DEATH 94A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 531 N.Potomac St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 32yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 531 N.Potomac St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William H.Whiteley

3 (b) If veteran, name war: --

3 (c) Social Security Account No.:

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Natalie Whiteley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept.25,1885

8. AGE: Years 62 | Months 0 | Days 2 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wm.t.Whiteley
13. Birthplace Md.

MOTHER
14. Maiden Name Fannie Michales
15. Birthplace Md.

16 (a) Informant Natalie Whiteley
(b) Address 531 N.Potomac St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept.30/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto, Md.

18 (a) Funeral director Phillips Harrington Sons
(b) Address 2024 Orleans St.

19 (a) (b) (Date received by registrar) Huntington Williams Registrar

SEP 29 1947

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27/47 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/6 1942 to 9/27 1947, and that I last saw h alive on 9/24 19 47

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles H. Gross M. D.
Address 325 Eutaw Pl. Date signed 9/29/47

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55522

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G55522 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTO
(c) City or town Bradshaw
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frankie Dorsey.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced:

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April - 1947

8. AGE: Years | Months: 5 | Days | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name George Dorsey
13. Birthplace Md.

MOTHER — 14. Maiden Name Maxine Lingham
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-30-47 (month) (day) (year)
(c) Cemetery or crematory Asbury Cem.
Location Loudon Park Cem Md

18 (a) Funeral director Mrs Frazier & Hemsley
(b) Address 578 N Bridle Rd

19 (a) SEP 29 1947 (Date filed) (b) by registrar Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 1947 at 12 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-27- 1947 to 9-28- 1947, and that I last saw her alive on 9-28- 1947

Immediate cause of death: Malnutrition — Duration: .3+4 mths
Due to: Subdural Hematoma
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Philip Brown
Address Johns Hop Hosp Date signed 9-29-47

411 976 G55523

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

930 X G55523 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTO.
(c) City or town SPARROWS POINT.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2308 Lodge Farm Road.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Luther Collier

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Matilda Collier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-11-1895

8. AGE: Years	Months	Days	If less than one day
52	3	15	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation mill wright
11. Industry or business

FATHER
12. Name Wesley Collier
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Shifflett
15. Birthplace Va.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 9-30-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern Ave.

18 (a) Funeral director Lilly + Zeiler Inc.
(b) Address 403 S. Wolfe St.

19 1947 (b) Lington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26 - 1947, at 2-A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 25 1947 to 9-26- 1947, and that I last saw him alive on 9-26- 1947

Immediate cause of death	Duration
Cardiac failure	7 mo.
Due to arterio-sclerotic heart disease	
Due to	
Other Conditions ? myocardial infarction	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. H. Sisson M. D.
Address Johns Hopkins Hosp. Date signed 9-29-47

X

G55524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G55524 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3242 O'Donnell St.
(c) Hospital or institution: NONE
(d) Length of stay in hospital or inst. (yrs., mos., or days) -
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3242 O'Donnell St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country - - -

3 (a) FULL NAME William John Kurek

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Married

6 (b) Name of husband or wife Margaret
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-17-1894

8. AGE: Years	Months	Days	If less than one day
52	10	8	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Merchant
11. Industry or business Hardware

FATHER 12. Name William Kurek
13. Birthplace ?

MOTHER 14. Maiden Name Agnes ?
15. Birthplace ?

16 (a) Informant Margaret Kurek - Wife
(b) Address

17 (a) Burial (b) Date thereof 9-30-47 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ St. Stanislaus
Location Dundalk Avenue.

18 (a) Funeral director Lilly + Zeiler Inc.
(b) Address 403 S. Wolfe St.

19 (a) (b) (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25 1947, at 11:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-17- 1941, to 9-25- 1947, and that I last saw him alive on 9-23- 1947.

Immediate cause of death	Duration
Coronary Occlusion	Sudden
Due to Coronary Thrombosis	1 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. J. Davidov M. D.
Address 3218 Eastern Ave Date signed 9-27-47

SEP 29 1947

G55525

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83A

G55525 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1305 Hull St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1305 Hull St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Antlitz Sr.
3 (b) If veteran, name war —
3 (c) Social Security Account No. 705-09-6226

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife Elizabeth Dennert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/22/1880

8. AGE: Years	Months	Days	If less than one day
67	3	7+	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired Tallyman
11. Industry or business B&O R.R.

FATHER
12. Name John Antlitz
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Smith
15. Birthplace Germany

16 (a) Informant Mrs. Rose Dehmitt
(b) Address 1305 Hull St.

17 (a) Burial (b) Date thereof 9/30/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location 4430 Gelsh Rd.

18 (a) Funeral director Charles F. Hill
(b) Address 1501 E. Fort Ave.

SEP 29 1947
(Date rec'd by reg.) (b) by Hampton Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 26 1947 at 4:45 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 9-21 1947 to 9-26 1947 and that I last saw him alive on 9-26 1947

Immediate cause of death	Duration
Cerebral Hemorrhage Massive	
Due to Cerebral arterio sclerosis & hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry W. D. Hollies
Address 2839 Walbrook Ave. Date signed 9/26/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 184

G55526
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Calvert
(c) City or town Barstow
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Frank Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1917

8. AGE: Years	Months	Days	If less than one day
30			hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Sober

11. Industry or business

FATHER
12. Name —
13. Birthplace

MOTHER
14. Maiden Name Mary Brooks
15. Birthplace Lewisa Md. Co

16 (a) Informant Mary Brooks
(b) Address Bowens Md

17 (a) Burial (b) Date thereof 10-1-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Camilla
Location Barstow Bowell Rt

18 (a) Funeral director
(b) Address Prince Frederick, Md
(Date received by registrar) (Huntington Williams, M.D.) Registrar

SEP 29

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-28- 1947, at 5 X 0 A. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemo-pneumo thorax, Rt

Due to Bullet wound of Rt Chest

Other Conditions Lobar pneumonia, Lft
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-24-47 5:45 P.M. 52-00
(b) Where did injury occur? Herring Dale Coates Co. Hillsboro
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Shot off of Both rifle.

23. Signature Carl H. Boyle M.D.
Medical Examiner.
Date signed 9-28-47

Dr. Home C55527
2108 St. Paul St.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 30D

✓ C55527 Registered No.

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2707 Berwick Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2707 Berwick Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Louise Bachman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Charles Bachman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19, 1905

8. AGE: Years	Months	Days	If less than one day
41	11	7	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Theodore Groth
13. Birthplace Germany

MOTHER
14. Maiden Name Amelia Muller
15. Birthplace Pa.

16 (a) Informant Mrs. Charles Bachman
(b) Address 2707 Berwick Avenue, 14

17 (a) Burial (b) Date thereof 9-30-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Baltimore, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

19 (a) Filed (b) Registrar

29 1947

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26, 1947, at 9a M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1943 to Sept. 26 1947 and that I last saw h[illegible] alive on Sept 26 1947.

Immediate cause of death	Duration
Acute Cardiac failure	6 hrs
Due to Dissection of Aorta	15 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas L. Todd M. D.
Address 2108 St Paul St Date signed 9/26/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55528

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

480

G55528 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 712 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edith R. Bundick

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	M.

6 (b) Name of husband or wife O. Ross Bundick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1891

8. AGE: Years	Months	Days	If less than one day
55	10	10	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Albert W. Smith
FATHER 13. Birthplace Canada
MOTHER 14. Maiden Name Lina V. Dix
MOTHER 15. Birthplace Va.

16 (a) Informant O. Ross Bundick
(b) Address 712 Park Heights Ave

17 (a) Burial (b) Date thereof 9-30-47 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore City

18 (a) Funeral director [illegible]
(b) Address 500 [illegible]

19 (a) Oct 2 1947 (b) [illegible] (Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27 1947, at 1125 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1947 to Sept 27 1947 and that I last saw her alive on Sept 25 1947.

Immediate cause of death	Duration
respiratory failure	
Due to metastatic carcinoma of lung	
Due to Carcinoma of uterus ?	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. C. Durrell Jr. M.D.
Address University Hosp. Date signed Sept 27

G55529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1849

G55529 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2015 Cheston Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2015 Cheston Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John C Gjerulff

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife: Maye B. Gjerulff

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1882

8. AGE: Years	Months	Days	If less than one day
65	0	20	hr. min.

9. Birthplace Denmark
(Town, county, and state)

10. Usual Occupation Maintenance

11. Industry or business U. S. Government

FATHER
12. Name Frederick Gjerulff
13. Birthplace Denmark

MOTHER
14. Maiden Name Jacobine Gjerulff
15. Birthplace Denmark

16 (a) Informant Mrs. Maye B. Gjerulff wife
(b) Address 2015 Cheston Ave.

17 (a) Burial (b) Date thereof 10/1/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 SEP 29 1947 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21 1947, at 1 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bronchopneumonia, of both lungs
Coronary arteriosclerosis.
Due to Fractured ribs (left 2-6)

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury 9-5-47 at ? M.
(b) Where did injury occur? Typewriter Service Co. 104 W. Fayette St
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? yes
(d) Means of injury Fall down steps

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 9-29-47

C55530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registration No. C55530

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1613 John St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 71 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1613 John St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALAN P. S. WALTHAM

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	215-05-0812

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of ~~husband~~ wife Mary Katherine Waltham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1876

8. AGE: Years	Months	Days	If less than one day
71	0	16	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation President
11. Industry or business Hilbert Optical Co.

FATHER
12. Name Charlton S. Waltham
13. Birthplace Harford Co. Md.

MOTHER
14. Maiden Name Georgianna Jessop
15. Birthplace Balto. Co. Md.

16 (a) Informant Mr. George A. Hilbert Jr.
(b) Address Ruxton, Md.

17 (a) Burial (b) Date thereof 9/30/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves., Balto. 17, Md.

19 (a) SEP 29 1947 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

V S 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH Sept. 28 1947, at 12:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 11 1947, to Sept 28 1947, and that I last saw h~~e~~ alive on 9/28/47 19

Immediate cause of death	Duration
(a) Pneumonia	6 days
(b) Rt lung.	
Due to (c)	
Due to (d)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W N Hoadley M. D.
Address 1403 Park Ave. Date signed 9/29/47

X

G55531 A-7645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1576

Registered No. G55531

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1312 Linden Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Scott H. White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-11-47

8. AGE: Years | Months 5 | Days 19 | If less than one day hr. min.

9. Birthplace W. Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name James White
13. Birthplace W. Va.

MOTHER — 14. Maiden Name Bessie (White) Queen
15. Birthplace W. Va.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9 29 47 (month) (day) (year)
(c) Cemetery or crematory
Location Clarksburg W. Va.

18 (a) Funeral director Wm. P. Dickman & Son
(b) Address North & Penna Ave

19 (a) SEP 29 1947 (Date received by Registrar) (b) Huntington West Virginia

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29- 1947 at 4 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-13- 1947 to 9-29- 1947 and that I last saw him alive on 9-29- 1947

Immediate cause of death: Bil. Peritonitis, following Operation — Duration

Due to for Biliary Atresia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Sept 20 1947

Major findings of operation: Biliary atresia

of autopsy: Above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A M Edmunds M. D.

Address JHH Date signed 9-29-47

555532

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131A

555532 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 521 Rossiter Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 521 Rossiter Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rose Garish Stevens

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Charles J Stevens
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 21 1881

8. AGE: Years 66 | Months 7 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Garish
13. Birthplace Ireland

MOTHER
14. Maiden Name Johanna Liffey
15. Birthplace Ireland

16 (a) Informant Charles J Stevens
(b) Address 521 Rossiter Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/30/47 (month) (day) (year)
(c) Cemetery or crematory Loyola Cathedral
Location Baltimore Md

18 (a) Funeral director Wilson & Son
(b) Address 1317 E Fayette St

19 (a) Date received by registrar SEP 30 1947 (b) Registrar Huntington Williams, M.D.

VS 750

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1947, at 5:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/4 1947, to 9/29 1947, and that I last saw her alive on 9/28 1947.

Immediate cause of death	Duration
Acute Pulmonary Edema	2 days.
Due to Hypertensive cardio vascular renal disease	at least 3 years.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Anthony J Thomas M. D.
Address 4600 York Rd Date signed 9/29/47

G55533

BALTIMORE CITY HEALTH DEPARTMENT

TN. 114034

CERTIFICATE OF DEATH

46M

Registered No. G55533

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Spring Grove Hospitals
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Maxwell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 20th 1877

8. AGE: Years	Months	Days	If less than one day
?70 70	1	9	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Samuel T. Maxwell
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Emma Gilbert
15. Birthplace Balto. Md

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastenn Ave (Records)

17 (a) Burial (b) Date thereof 10/1/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook
(b) Address 1217 St. Paul St.

19 SEP 30 1947 (b)
(Date rec'd by Registrar) (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 29th 1947, at 4.00 A.M. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 24/ 1947, to Sept 29th 1947, and that I last saw her alive on Sept 29th 1947

Immediate cause of death: Carcinomatosis, General Peritoneal Cavity — Duration: months

Due to:

Due to:

Other Conditions: Uterine fibroids yrs.

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rush E. Butterville M. D.

Address Balt. City Hosp. Date signed 9/29/47

55534 BC# 289863

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160 A

✓ G55534 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address none
(c) Hospital or institution: Hospital for the Women of Md. 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1338 W. 41st St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Waleton

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1947

8. AGE: Years | Months | Days: 0 | If less than one day: 4 hr. 30 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business —

FATHER
12. Name Francis Leslie Waleton
13. Birthplace Louisville Ky.

MOTHER
14. Maiden Name Lillian Emma Johnson
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Lillian Emma Waleton
(b) Address 1338 W. 41st Street, Balto, Md.

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 10/1/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1207 St. Paul St.

19 SEP 30 1947 (Date received by Registrar) (b) Huntington Nottingham M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 29, 1947, at 12 ~~M~~ AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 22, 1947, to Sept 29, 1947, and that I last saw her alive on Sept. 29, 1947.

Immediate cause of death	Duration
Intracranial Hemmorhage	
Due to Injury during birth	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Vernon C. Kelly M. D.
Address Date signed

X

55535

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ C55535 Registered No.

470

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3716 Delvenne Ave
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3716 Delvenne Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Frank N. Bryan

3 (b) If veteran, name war: W. W. #1

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, ~~married, widowed, or divorced~~: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 3rd 1894

8. AGE: Years 53 | Months 7 | Days 26 | If less than one day ... hr. ... min.

9. Birthplace Mississippi
(Town, county, and state)

10. Usual Occupation Warehouse Supt.

11. Industry or business Camp Holabird

FATHER — 12. Name F. L. Bryan
13. Birthplace Miss.

MOTHER — 14. Maiden Name Mary L. Quinn
15. Birthplace Miss

16 (a) Informant Myrtle C. Sowers
(b) Address 3716 Delvenne ave

17 (a) Removal (b) Date thereof 9/30/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Carmel
Location Hazlehurst, Miss

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St

SEP 30 1947 (Date rec'd by registrar) (b) Huntington for Williamsburg, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29th 1947, at 11 35 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1947 to Sept 29 1947, and that I last saw him alive on Sept 25 1947.

Immediate cause of death: Carcinomatosis — —
Metastasis to Brain —
Due to Carcinoma of Left Lung
Due to —
Other Conditions —

Duration
Sept 29/47

(Include pregnancy within 3 months of death)
Date of operation Dec 20 - 1946
Major findings of operation: "Oat cell" Bronchogenic Carcinoma (left)
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Louis N. Simmons M. D.
Address 722 N. Kenwood Ave Date signed

Had left pneumonectomy at Henry Ford Hospital Detroit - March. X Sept 29 (47)

G55536

BALTIMORE CITY HEALTH DEPARTMENT ✓ G55536
CERTIFICATE OF DEATH 1140 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 912 Booth
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H. Castle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-28-1905

8. AGE: Years 42 | Months 1 | Days 0 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Handy Man

11. Industry or business

FATHER
12. Name Lawrence Castle
13. Birthplace Md

MOTHER
14. Maiden Name Lottie Sampson
15. Birthplace Md

16 (a) Informant Mazie V. Musel
(b) Address 517 N. Calhoun St

17 (a) B. (b) Date thereof 10-2-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Star
Location Balto. Co

18 (a) Funeral director Samuel M. Sullivan Jr
(b) Address 1011 N. Arlington Ave

19 (a) SEP 30 1947 (Date rec'd by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/28 1947, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 19, to Sept 28 1947, and that I last saw h alive on 9/28 1947.

Immediate cause of death	Duration
Brain abscess	
Due to Infected embolism	
Multiple lung abscesses	duhm
Due to Emphysema	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 9/27/47
Major findings of operation: Lung abscess right lower lobe.
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. S. Hallyn M. D.
Address Univ. Hosp. Date signed 9/29/47

G55537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G55537
Registered No.

CM. 112796

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 & 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 39 W. West ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Williams

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. -1-1907

8. AGE: Years	Months	Days	If less than one day
40	8	27	hr. min.

9. Birthplace S.C.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Seirious Williams
13. Birthplace S.C.

MOTHER
14. Maiden Name Patsy Williams
15. Birthplace S.C.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern AVE.

17 (a) Burial (b) Date thereof OCT 2 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mayerville
Location Mayerville

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) SEP 30 1947 (b) Signature of registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 1947, at 5.20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-6-1947, to 9-28-1947, and that I last saw him alive on 9-28-1947.

	Duration
Immediate cause of death Respiratory failure	5 wk
Due to Tuberculosis of lungs, far advanced	1 yr.
Due to	
Other Conditions Secondary bronchostenosis	1 year

(Include pregnancy within 3 months of death)

Date of operation 4-24-47

Major findings of operation Bronchoscopic finding of bronchial stenosis

of autopsy Will advise

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph J Bowen Jr M. D.
Address Balto City Hosp Date signed 9-29-47

55538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12 V

Registered No. G55538

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4days
(e) Length of stay in Baltimore (yrs., mos., or days) 50yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 517 Rock Glen Road, Baltimore
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Paul H. Ziefle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mrs. Alene Clark Ziefle
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) Sept 23, 1897

8. AGE: Years	Months	Days	If less than one day
50	0	4	____hr. ____min.

9. Birthplace Baltimore, Baltimore Co, Md.
(Town, county, and state)
10. Usual Occupation Sun Paper Carrier, Real Estate
11. Industry or business

FATHER
12. Name Mr. John Ziefle
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Elizabeth Bien
15. Birthplace ?

16 (a) Informant wife
(b) Address 517 Rock Glen Road, City 39

17 (a) Burial (b) Date thereof Sept 30 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3501 Frederick Ave

18 (a) Funeral director Henry H Withe
(b) Address 4101 Edmondson Ave

Sep 30 1947 Huntington Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27 1947, at 1:40 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 23 1947, to Sept. 27 1947, and that I last saw h.r. alive on Sept. 27 1947.

Immediate cause of death	Duration
Acute hemorrhagic pancreatitis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Sept. 23, 1947
Major findings of operation: Acute hemorrhagic pancreatitis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Samuel C Bell
Address Union Memorial Hosp Date signed Sept 27 D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55539

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122A

Registered No. G55539

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St
(c) Hospital or institution: Bon Secours Hosp 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 61 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County ——
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3209 Belmont Ave # 16
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MRS MARGARET E. McDONNELL

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife MR WILLIAM McDONNELL
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-12-86

8. AGE: Years	Months	Days	If less than one day
61	0	16	hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name James Flynn
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Kearney
15. Birthplace Baltimore, Md.

16 (a) Informant Wm. McDonnell
(b) Address 3209 Belmont Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 10/1/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location Lot 300 Old Fed Rd.

18 (a) Funeral director John J. Cowgill Son
(b) Address 901-03 S. Collins St.

1947 SEP 29 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

A 99 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28 1947, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21 1947 to Sept 28 1947 and that I last saw h[illegible] alive on Sept 28 1947.

Immediate cause of death Uremia — Duration

Due to Chronic Glomerulo Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 9-22-47
Major findings of operation: R Inguinal Hernia
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature George W. Fisher M. D.
Address Bon Secours Hosp Date signed 9-29-47

C55540 — BALTIMORE CITY HEALTH DEPARTMENT — C55540

CERTIFICATE OF DEATH

131A

LN. 113421

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure that the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 520 Lanvale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Martha Fennell

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept ? 1887

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Abraham McGraw
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Dorsey
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-1-47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore

18 (a) Funeral director Wm Frazier & Henderson
(b) Address 578 W Baltimore St

19 (a) SEP 30 1947 (Date rec'd by Reg.) (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27/1947 19 , at 3.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 29 19 47, to Sept 27 19 47, and that I last saw h er alive on Sept 27th 19 47.

Immediate cause of death Renal failure. — Duration

Due to Arteriolarnephrosclerosis & hypertensive cardio

Due to Vascular disease.

Other Conditions Cystic & mitral stenosis & heart

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. T. Bonfanti M. D.
Address Balt City Hosp Date signed 9-29-47

55541 DC# 089907

BALTIMORE CITY HEALTH DEPARTMENT ✓ G55541

CERTIFICATE OF DEATH 161 C

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline
(c) Hospital or institution: St. Joseph's Hospital b'
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2hr 5min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 137 N. Milton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Butta

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/29/47

8. AGE: Years	Months	Days	If less than one day
\	\	\	2 hr. 5 min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation at Home.

11. Industry or business

FATHER 12. Name Joseph S Butta

13. Birthplace Balto. Butta

MOTHER 14. Maiden Name Dennis Connie

15. Birthplace Balto Connie

16 (a) Informant Joseph S Butta

(b) Address 137 N. Milton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/30/47 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Rd.

18 (a) Funeral director John G Connelly.

(b) Address 419 Eastern Ave

SEP 30 1947 (Date received by Registrar) (Signature) Huntington Williams, M.D.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/29/ 1947 at 9:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/29/ 1947 to 9/29/ 1947 and that I last saw h[illegible] alive on 9/29/ 1947.

Immediate cause of death	Duration
Aspiration, failure	
Due to Congenital anomalies	
Due to	
Other Conditions Bilateral Cyanosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: CONGENITAL ATELECTASIS LUNGS

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas J. Houska M.D.

Address 1 E. Jos. St. Balto. Date signed 9/29/47

G55542

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G55542
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Be sure to give correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 20 N. Caroline Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 20 N. Caroline Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Grimes

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-07-1648

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
m	c	Married

6 (b) Name of husband or wife Ollie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace D. C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Wesley Grimes
13. Birthplace D. C.

MOTHER
14. Maiden Name Carrie Orr
15. Birthplace D. C.

16 (a) Informant Ollie Grimes
(b) Address 1433 E. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/1/47 (month) (day) (year)
(c) Cemetery or crematory Ent. Calvary
Location Balto. Co., Md.

18 (a) Funeral director Joseph L. Lowe
(b) Address 1136 N. Central Ave.

19 SEP 30 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/26/47 19 at 4:10 p.m.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH pulmonary Hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Evans M.D.
Medical Examiner.
Date signed 9/27/47

G55543

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

Registration No. G55543

(OVER)

Every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Special attention to correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Ave.
(c) Hospital or institution: Maryland Gen. Hospital
(d) Length of stay in hospital or inst. ([illegible], or days) 29
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 24
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1116 S. Bouldin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Catherine E. Meurer (MEURER)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: White

6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife: Wm F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7 Jan. 1888

8. AGE: Years 59 | Months 8 | Days 21 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Frederick Woolsheleger
13. Birthplace Baltimore

MOTHER
14. Maiden Name Lottie Phieffer
15. Birthplace Baltimore

16 (a) Informant William Meurer
(b) Address 1116 S. Bouldin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/1/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) 30 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 Sept. 1947 at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10 Sept. 1947, to 28 Sept. 1947, and that I last saw her alive on 28 Sept. 1947.

Immediate cause of death: Cardiac decompensation — Duration

Due to Arteriosclerotic C.V.D.; Amputation 3rd left leg (mid thigh)

Due to Diabetes mellitus

Other Conditions Tuberculosis left hip; abscess abdominal wall.
(Include pregnancy within 3 months of death)

Date of operation 10 Sept 1947; 27 Sept (19)47

Major findings of operation: (1) Abscess and wall (2) Thrombosis popliteal vessels, left leg.

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. T. McGowan M. D.

Address Maryland Gen. Hosp. Date signed 28 Sept 1947

55544

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83A

Registered No. G55544

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1743 E. Federal St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1743 E. Federal St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howerd L. Hanson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Agness C. Wenzel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1883

8. AGE: Years	Months	Days	If less than one day
64	4	14	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Guard
11. Industry or business Pinkerton Inc.

FATHER
12. Name Edward
13. Birthplace Baltimore

MOTHER
14. Maiden Name May McGaw
15. Birthplace Baltimore

16 (a) Informant Agness C. Hanson
(b) Address 1743 E. Federal St.

17 (a) Burial (b) Date thereof 10/2/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Frederick Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) S.O. 1017 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 1947, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19 1947 to Sept 27 1947 and that I last saw h-m alive on Sept 28 1947.

Immediate cause of death	Duration
Edema Lungs	2 days
Due to Cerebral Hemorrhage	10 day
Due to	
Other Conditions Arterio-Sclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall
Address 1631 E. North Av Date signed 9/29/47 M. D.

G55545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

Registered No. G55545

CWK-112024

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Mos & 19 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town 717 Mosher Street (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife Sam Davis (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 12, 1876

8. AGE: Years	Months	Days	If less than one day
70	11	16	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry Bell
13. Birthplace Maryland

MOTHER
14. Maiden Name Maranda Johnson
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, removal) (b) Date thereof Oct. 1 1947 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem. Co.
Location Balto. Co.

18 (a) Funeral director Mrs. Geo. N. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) Date rec'd (by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 28 1947, at 11:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 9 1947, to Sept. 28 1947, and that I last saw h alive on Sept. 28 1947.

Immediate cause of death Liver Abscess — Duration

Due to Chronic Cholecystitis & Cholelithiasis & Erosion of stone into liver & Pancreas

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: See above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. T. Binford, M. D.
Address Balt. City Hosp. Date signed 9-29-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G55546

413000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

16 131 A

Registered No. G55546

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1109 Harlem, Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Addison

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife James Addison
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) 11-22-15

8. AGE: Years 31 | Months 10 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housemaid

11. Industry or business

FATHER
12. Name William Hicks
13. Birthplace Md.

MOTHER
14. Maiden Name Florence Holmes
15. Birthplace S. C.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 2, 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto. Co.

18 (a) Funeral director Mrs. Geo. K. Holland
(b) Address 1631 Druid Hill Ave.

19 Filed Oct 3 1947 (b) Cemetery for Williams, Md.
(Date filed by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 1947, at 1 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-16 1947 to 9-28 1947, and that I last saw her alive on 9-28 1947.

Immediate cause of death Uremia — Duration 5 months

Due to Chronic nephritis

Due to ? arteriolar nephrosclerosis ?? glomerulonephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Hoban

Address 1 NN Date signed Oct 2nd 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

55547

BALTIMORE CITY HEALTH DEPARTMENT ✓ G55547

CERTIFICATE OF DEATH 30 D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hosp. Tel 7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4409 Buchanan Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Warner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Laura A. Warner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 19, 1890

8. AGE: Years	Months	Days	If less than one day
57	7	9	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Painter
11. Industry or business Wasserton Apts.

FATHER
12. Name Wm. F. Warner
13. Birthplace Maryland

MOTHER
14. Maiden Name Emma J. Leonard
15. Birthplace Maryland

16 (a) Informant Mrs. Ethel J. Ackendon
(b) Address 3424 Chestnut Ave

17 (a) Burial (b) Date thereof Oct 1/47.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location

18 (a) Funeral director Chenoweth & Donovan
(b) Address 3615-17 Chestnut Ave

SEP 30 19[illegible]
(Date rec'd by registrar) (b) Huntington Hill Registrar M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 28 1947, at 2305 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 27 1947 to Sept 29 1947 and that I last saw h[illegible] alive on Sept 28 1947

Immediate cause of death	Duration
Dissecting Aneurysm	
Due to Arteriosclerotic Vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John A. Lightowler M. D.
Address University Hosp Date signed 9-29-47

X

G55548

BALTIMORE CITY HEALTH DEPARTMENT 17A

CERTIFICATE OF DEATH

G55548 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring Ave
(c) Hospital or institution: Children's Hospital School 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 48 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3632 Roland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Francis T. Warren

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/7/30

8. AGE: Years	Months	Days	If less than one day
17	2	22	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Ward R. Warren
13. Birthplace Md.

MOTHER
14. Maiden Name Alice B. Foreman
15. Birthplace Md.

16 (a) Informant Ward R. Warren.
(b) Address 3632 Roland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 4, 1947 (month) (day) (year)
(c) Cemetery or crematory Lutheran. Location Uniontown Md.

18 (a) Funeral director Kenneth W. Donovan
(b) Address 3615-12 Keatonst Ave

SEP 30 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 Sept 1947 at 12 40/5 M

21. I certify that death occurred on the date above stated; that I attended deceased from 31 May 1946 to 29 Sept 1947 and that I last saw h~~im~~ alive on 27 Sept 1947

Immediate cause of death	Duration
Cerebral Embolism	
Due to Mitral Insufficiency Rheumatic Endocarditis Pericarditis & TBC	
Due to Left Hemiplegia	
Other Conditions Fever during Illness, Cerebral Embolism (Include pregnancy within 3 months of death)	

Date of operation 23 Aug 46, 27 Nov 46
Major findings of operation: Incision & drainage of Inguinal & Retroperitoneal abscesses
Results of autopsy: Lumbar abscesses

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature Louis W. Sweeten M. D.
Address Children's Hospital School Date signed 29 Sept 47

55549

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G55549 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please correct age is especially important. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave & MADISON ST.
(c) Hospital or institution: MARYLAND GENERAL HOSPITAL 13 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 706 W. 34th (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN MATHIAS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife (Illegible) SARAH C.

6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) 9/19/69

8. AGE: Years 78 | Months 0 | Days 09 | If less than one day ____ hr. ____ min.

9. Birthplace WESTMINSTER, MARYLAND (Town, county, and state)

10. Usual Occupation RETIRED

11. Industry or business NONE

FATHER
12. Name CORNELIUS MATHIAS
13. Birthplace MARYLAND

MOTHER
14. Maiden Name MARIE SHEETS
15. Birthplace MARYLAND

16 (a) Informant MRS. DANIEL McCLELLAND
(b) Address 1114 WOOD HGTS. AVE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 1/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location

18 (a) Funeral director Chenoweth & Donovan
(b) Address 3615-17 Chestnut Ave.

19 (a) SEP 30 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

98 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/26 1947, at 3:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/27 1947, to 9/25 1947, and that I last saw him alive on 9/25 1947.

Immediate cause of death	Duration
CARDIAC DECOMPENSATION	
Due to ARTERIOSCLERDTIC CARDIO-VASCULAR DISEASE	
Due to SENILITY, URINARY SUPPRESSION	
Other Conditions BENIGN PROSTATIC HYPERTROPHY	

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation:

of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul G. Herold M. D.
Address Md. Gen. Hospital Date signed 9/29/47

55550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83 A

Registered No. C55550

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — Sinai Hospital
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3314 Royace Ave
(If rural give location)
(e) Citizen of foreign country? Royce (Yes or No)
If yes, name country

3 (a) FULL NAME MORRIS KOERIN

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-4880A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Married

6 (b) Name of husband or wife Rebecca

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1882

8. AGE: Years	Months	Days	If less than one day
65	5	12	hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation
11. Industry or business Clothing Presser

FATHER
12. Name David Koerin
13. Birthplace Russia

MOTHER
14. Maiden Name Sophia Cohen
15. Birthplace Russia

16 (a) Informant Rebecca Koerin
(b) Address 3314 Royce Ave

17 (a) Burial (b) Date thereof Sept 30, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director SOl Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) SEP 30 1947 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28 1947, at 10:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/23 1947 to 9/28 1947, and that I last saw him alive on 9/28 1947

Immediate cause of death	Duration
Bronchopneumonia	5 days
Due to Cerebral Hemorrhage	5 days
Due to Hypertension and Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Oscar Koerin M. D.
Address Sinai Hospital Date signed

55551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131A

Registered No. 655551

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 917 Pierce St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 917 Pierce St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MAGGIE JOHNSON

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: None

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife:

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/7/1884

8. AGE: Years	Months	Days	If less than one day
63	5	20	hr. min.

9. Birthplace Charles County, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Butler
13. Birthplace Charles County, Md.

MOTHER
14. Maiden Name Nancy
15. Birthplace Charles County, Md.

16 (a) Informant Thomas Ruff(Bro.in Law)
(b) Address 917 Pierce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/30/47 (month) (day) (year)
(c) Cemetery or crematory Western Star
Location Catonsville, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N.Carrollton Ave

SEP 30 1947 (Date rec'd by registrar) (d) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH 9/27/47 19 , at 8:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/23 1947 to 9/27 1947, and that I last saw h[illegible] alive on 9/26 1947.

Immediate cause of death Cardiac Irregular Rhythm — Duration 1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. A. Jackson M.D.

Address 600 Washington Ave Date signed 9/30/47

55552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 A

G55552 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 Fleet St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Barosky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-27-06.

8. AGE: Years 41 | Months 4 | Days 20 | If less than one day hr. min.

9. Birthplace S.C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Allen Johnson
13. Birthplace S.C.

MOTHER
14. Maiden Name Florence Price
15. Birthplace S.C.

16 (a) Informant Relative
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-30-47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A-A-Col.

18 (a) Funeral director Wm S. Fialkowski
(b) Address 2007 Eastern Ave

19 (a) Date received by registrar SEP 30 1947 (b) Huntington Wil...

V S 190 ....

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17 1947, at 11:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 5 1947 to Aug 17 1947 and that I last saw h[illegible] alive on Aug 17 1947.

Immediate cause of death	Duration
Respiratory & cardiac Collapse.	
Due to uremia -	
Due to Epidermoid carcinoma of cervix.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation none / autopsy
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert P. O'Donnell. M. D.
Address Johns Hopkins Hosp. Date signed Aug 17 1947

55553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G55553
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 206 E. 25th Street
(c) Hospital or institution: 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 206 E. 25th Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ELIZABETH HENDERSON

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Femak
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Alfred Henry Henderson
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): July 27, 1864

8. AGE: Years	Months	Days	If less than one day
83	2	2	— hr. — min.

9. Birthplace: Spring Valley, N. J. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: At Home

FATHER
12. Name: David Henry Hopper
13. Birthplace: New Jersey

MOTHER
14. Maiden Name: Sarah M. Van Riper
15. Birthplace: New Jersey

16 (a) Informant: Sarah Henderson
(b) Address: 206 E. 25th St., Balto. 18, Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/30/1947 (Month) (Day) (Year)
(c) Cemetery or crematory: Steward & Hill F. H.
Location: Hackensack, New Jersey

18 (a) Funeral director: John Burns' Sons
(b) Address: Towson, Md.

19 (a) SEP 30 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28, 1947, at 7:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 20 1947 to Sept 28th 1947 and that I last saw h.er alive on 28 Sept 1947

Immediate cause of death: Heart Failure — Duration: 1 day

Due to: Arteriosclerotic Cardio-Vascular Disease — 10 years

Due to: Senility

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 2050 Harford Rd Date signed M. 9 D. 29 Sept. 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

55554 TN. 113204

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55B

G55554 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-month
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 629 Washington Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Melvin Howard Schillinberg

3 (b) If veteran, name war: none
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Mabel Mary Schillinberg
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20th 1879

8. AGE: Years 68 | Months 6 | Days 9 | If less than one day: hr. min.

9. Birthplace Maryland (Balto.)
(Town, county, and state)

10. Usual Occupation Iron Worker

11. Industry or business Retired

FATHER
12. Name Wilbur Schillinberg
13. Birthplace Maryland

MOTHER
14. Maiden Name Fanny Stallings
15. Birthplace Maryland (Balto.)

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 SEP 30 1947 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION A.M

20. DATE OF DEATH September 29th 1947 at 4.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 21/1947 to Sept 29th 1947 and that I last saw h. im alive on Sept. 29th 1947.

	Duration
Immediate cause of death Melanoma	
= generalized metastases	
Due to	
Due to	
Other Conditions Terminal bronchopneumonia	
(Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. T. Bunford M. D.
Address Balt. City Hosp Date signed 9-29-47

55555

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1948

Registered No. C55555

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 451 N. Ellwood Av
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 451 N. Ellwood Av
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henrietta A. Pettalista

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Chas. Sr.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19 1870

8. AGE: Years 77 Months 7 Days 8 If less than one day hr. min.

9. Birthplace Sefton Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name John W. Disney
13. Birthplace A. A. Co.

MOTHER
14. Maiden Name Susan Harrison
15. Birthplace Virginia

16 (a) Informant Susan Pettalista
(b) Address 451 N. Ellwood Av.

17 (a) Burial (b) Date thereof Oct. 1 - 47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location Loyld. Ont.

18 (a) Funeral director John J. Madon
(b) Address 3006 E. Balto St.

19 (a) SEP 30 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/22 1947, to 9/27 1947, and that I last saw h[illegible] alive on 9/26 1947.

Immediate cause of death Coronary Thrombosis — Duration 7 days

Due to

Due to

Other Conditions Chronic Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edwin H. Scarbrough M.D.

Address 1934 E. Eller[illegible] Date signed 9/29/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

55556 TN. 109262

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 46 A

Registered No. G55556

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6- & 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town ~~Sinex~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 410 S. Conklin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Halbert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 19th 1882

8. AGE: Years	Months	Days	If less than one day
65	6	8	hr. min.

9. Birthplace Scotland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Chas Halbert
13. Birthplace Scotland

MOTHER
14. Maiden Name Jennie Dundear
15. Birthplace Scotland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (b) Date thereof Oct 1-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location O'Donnell St

18 (a) Funeral director John P. Connelly
(b) Address 410 Eastern Ave.

19 SEP 20 1947 Baltimore, Md.
(Date filed by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27th 1947 19 , at 10.35 A.M. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 16/ 1947 to Sept 27 19 47 and that I last saw him alive on Sept 27 19 47.

Immediate cause of death	Duration
Small intestine obstruction	5 da
Due to Adhesions	5 wk
Due to Gastrectomy for Carcinoma of Oesophagus	4 mo
Other Conditions Pulmonary tuberculosis	10 mo

(Include pregnancy within 3 months of death)

Date of operation 8-12-47

Major findings of operation: Carcinoma of oesophagus (squamous cell)

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph J. Burden Jr M. D.
Address Balt City Hosp Date signed 9-29-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct; age is especially important. Physicians: please write the causes of death clearly and legibly.

55557 BC# 90182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160 A

Registered No. G55557

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens
(c) Hospital or institution: St. Agnes Hosp. 6W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Caton & Wilkens Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Dougherty (Edward J. Dougherty Jr)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 26 - 1947

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward J. Dougherty
13. Birthplace Balto Maryland

MOTHER
14. Maiden Name Catherine F. Flanagan
15. Birthplace Balto Maryland

16 (a) Informant Edward J. Dougherty
(b) Address 2446 Lanvale St

17 (a) Burial (b) Date thereof Sept 30-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto Md

18 (a) Funeral director Pratt & B. M. Walker
(b) Address Pratt & Chucker Sts

19 SEP 30 1947 (b) Huntington Williams, M.R.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/29 1947, at 11:26 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/26 1947, to 9/29 1947, and that I last saw him alive on 9/29 1947.

Immediate cause of death	Duration
Due to Intra cranial Hemorrhage and Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles V. Bowen, Jr. M. D.
Address St. Agnes Hospital Date signed 9/29/47

X

G55558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

G55558

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 323 Hanover St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 323 Hanover St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma E. Pfuttner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Alberta Pfuttner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/28/1878

8. AGE: Years 68 | Months 9 | Days 1 | If less than one day hr. min.

9. Birthplace: Penn. (Town, county, and state)

10. Usual Occupation: Home Keeper

11. Industry or business

FATHER
12. Name: Joseph Sites
13. Birthplace: Penn.

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Penn.

16 (a) Informant: Mrs A. E. Pfuttner
(b) Address: 323 Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/47 (month) (day) (year)
(c) Cemetery or crematory: Holy Cross
Location: Ritchie Highway

18 (a) Funeral director: D. Baker Sons
(b) Address: 131 Light St

SEP 30 1947 (Date rec'd by registrar) (Signature) Wallace Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/29 1947 at 1000 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to 9/29 1947 and that I last saw h. alive on Sept 25 1947.

	Duration
Immediate cause of death: Hypertension Cardiovascular Disease	1 yr
Due to:	
Due to: Terminal uremia	
Other Conditions: Chronic nephritis	3 Mo.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: E. Pfuttner M. D.
Address 107 E. Wolvr Date signed 9/30/47

G55559

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No. G55559

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 138 No Collington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry Friedman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Katie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Samuel
13. Birthplace Russia

MOTHER
14. Maiden Name Sadie
15. Birthplace Russia

16 (a) Informant Julius Friedman
(b) Address 138 No Collington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-1-47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Young Men A.R. Assn
Location Windsor Mill Rd.

18 (a) Funeral director Jack Lewis, Inc.,
(b) Address 2100 Eutaw Place

19 Oct 1 1947 Covington Williams, Registrar (Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-29-1947, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-26 1947 to 9-29 1947 and that I last saw him alive on 9-29 1947

Immediate cause of death: Subacute bacterial endocarditis — Duration

Due to: verruca mitral valve

Due to:

Other Conditions: Horseshoe kidney

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: verruca mitral valve

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elliott F. Weitzman M. D.

Address Sinai Hosp Date signed 9-29-47

G55560 BALTIMORE CITY HEALTH DEPARTMENT G55560

CERTIFICATE OF DEATH ✓ 83A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5229 Reisterstown Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5229 Reisterstown Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lula J. Watson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Robert H. Watson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 27, 1873

8. AGE: Years	Months	Days	If less than one day
73	11	2	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name William Henry Riley
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Ellen Beckley
15. Birthplace Howard County, Md.

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 2, 1947 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Woodlawn Cemetery

18 (a) Funeral director Miles Lamotray
(b) Address 4510 Liberty Heights Ave.

(a) SEP 30 1947 (Date rec'd by registrar) (b) Certificate for William Riley

VS - 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 29 1947, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 24 1947 to Sept 29 1947. and that I last saw h er alive on Sept 27 1947.

Immediate cause of death	Duration
Cerebral hemorrhage + paralysis	5 days
Due to	
Due to advanced arterio - sclerosis + hypertension	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hattie D. Tuttle M. D.
Address 2220 Garrison Blvd. Date signed 9/30/47

X

G55561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 930

G55561

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4909 Haddon Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4909 Haddon Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emily Mary O'Malley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife James J. O'Malley
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) October 4, 1897

8. AGE: Years	Months	Days	If less than one day
49	11	25	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Louis Romm
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Clara Blotkamp
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. James J. O'Malley
(b) Address 4909 Haddon Ave.

17 (a) Burial (b) Date thereof Oct. 1, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location Baltimore, Md.

18 (a) Funeral director Ellis Funeral Home
(b) Address 4810 Liberty Heights Ave.

19 (a) Huntington Williams M.D.
(Date rec'd by registrar)

VS-150 SEP 30 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH September 29 1947, at 2.15A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 26 1947, to Sept. 29 1947, and that I last saw her alive on Sept. 28 1947.

Immediate cause of death	Duration
I Cerebral Hemorrhage	3½ days.
Due to	
Due to	
Other Conditions Hypertension and Heart disease	5 yrs.

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Earl L. Thurston M. D.
Address 4108 Liberty Hgts Ave Date signed

83A

G55562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193D

~~G55562~~

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3611 Fairhaven Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore 30 (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3611 Fairhaven Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Gertrude Rebecca Hudson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife George T. Hudson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20-1868

8. AGE: Years 79 | Months 6 | Days 8 | If less than one day hr. min.

9. Birthplace Washington D. C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Samuel a Meginney
13. Birthplace Easton Md

MOTHER
14. Maiden Name Lucinda Arrington
15. Birthplace Md

16 (a) Informant Miss M. Hudson
(b) Address 3611 Fairhaven Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 2-47 (month) (day) (year)
(c) Cemetery or crematory St Peters Cemetery
Location Queenstown, Md.

18 (a) Funeral director Milton Schilling
(b) Address 3914 Hanover St. Zone 25

19 (a) Sept 30 1947 (b) (Date rec'd by registrar) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28th 1947 at 7.01 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 18 1947 to Sept 28 1947 and that I last saw h[illegible] alive on Sept. 28 1947.

Immediate cause of death: Myocardial Degeneration — Duration: 10 Weeks
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H R Johnson M.D.
Address 403 Medical Arts Bldg Date signed 9-30-47

G55563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 131B

G55563 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5303 Purlington Way
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5106 York Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD M. DUNCAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Miriam Dulaney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/8/60

8. AGE: Years	Months	Days	If less than one day
86	10	21	hr. min.

9. Birthplace Baltimore Co. Maryland (Town, county, and state)
10. Usual Occupation Medical Doctor
11. Industry or business

FATHER
12. Name John D. C. Duncan
13. Birthplace Maryland

MOTHER
14. Maiden Name Catherine E. Jones
15. Birthplace Maryland

16 (a) Informant Mrs Miriam D. Duncan
(b) Address 5106 York Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/1/47 (month) (day) (year)
(c) Cemetery or crematory Jessops Cemetery
Location Cockeysville, Maryland

18 (a) Funeral director H. H. Mears and Son
(b) Address 805 N. Calvert St.

19 (a) SEP 30 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 Sept 1947, at 1.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/18 1947 to 9/29 1947, and that I last saw him alive on 9/29 1947.

Immediate cause of death	Duration
UREMIA	
Due to Chronic Glomerulo Nephritis	
Due to	
Other Conditions Arteriosclerotic Heart Disease, Bronchopneumonia,	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Theodore E. Woodward M.D.
Address 11 E. Chase St Date signed 9/30/47

X Baltimore 2, Md

G55564 over G55564

BALTIMORE CITY HEALTH DEPARTMENT

Registered No. .....

CERTIFICATE OF DEATH 93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway + Fairmount Ave
(c) Hospital or institution:
Church Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 43 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5802 Roland Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME Leitch, Mrs. Susan / Susie C

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Mr. Milton Leitch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 13, 1864

8. AGE: Years	Months	Days	If less than one day
82	9	01	..... hr. ..... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Toland, James
13. Birthplace Penna.

MOTHER
14. Maiden Name Collins, Sarah
15. Birthplace England

16 (a) Informant The patient
(b) Address .....

17 (a) Burial (b) Date thereof Oct 2/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount Ave & North

18 (a) Funeral director John O. Mitchell Home
(b) Address 1900 Eutaw Place

19 (a) ..... (b) .....
(Date rec'd by registrar) Registrar

SEP 30 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 1947, at 8:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 18 1947 to Sept 30 1947, and that I last saw h.e.r. alive on Sept 29 1947

Immediate cause of death Cardiac Insufficiency — Duration Diagnosed Aug 11, 1947

Due to Arteriosclerotic heart disease

Due to .....

Other Conditions Arteriosclerosis generalized
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury None

23. Signature J. Robert Haase M. D.

Address Church Home + Hosp. Date signed 9/30/47

X

G55565 BALTIMORE CITY HEALTH DEPARTMENT G55565
CERTIFICATE OF DEATH 131a
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 709 W. Lafayette Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 709 W. Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cordelia - Delia Johnson.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife James Johnson.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 61 | Months | Days | If less than one day hr. min.

9. Birthplace Charles County, Md.,
(Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER 12. Name James Short,
13. Birthplace Charles County Md.

MOTHER 14. Maiden Name Mary E. Frederick
15. Birthplace Charles County Md.

16 (a) Informant Mrs. Mary Walters
(b) Address 2240 Penna. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-1-1947 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 3221 W. Lebroder St

19 (a) (Date rec'd by Registrar) (b) Huntington Williams, Registrar

SEP 20 1947
180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1947 at 9.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1947 to Sept 26 1947 and that I last saw h[illegible] alive on Sept 26 1947

Immediate cause of death	Duration
Cardio - Vascular - Renal Diseases	Several Years
Due to —	
Due to —	
Other Conditions Senility	—

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature N. P. Stephen M. D.
Address 825 N. Fremont Ave Date signed 9.29.47

G55566

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G55566

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ Mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 200 Hopkins Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Siekler, Mr. Leonard

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married (Widower)

6 (b) Name of husband or wife: Ethel Margaret Siekler

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Dec. 11, 1873

8. AGE: Years 74 | Months 9 | Days 18 | If less than one day ____ hr. ____ min.

9. Birthplace New Jersey (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Empire Construction Co.

FATHER — 12. Name John Siekler
13. Birthplace New Jersey

MOTHER — 14. Maiden Name Cordelia Power
15. Birthplace Penn.

16 (a) Informant Mr. Francis White
(b) Address 200 Hopkins Rd.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept 30/47 (month) (day) (year)
(c) Cemetery or crematory Hendrickson Sons
Location Tyrone Pa

18 (a) Funeral director Philip Herring Sons
(b) Address 2024 Orleans St

19 (a) 1947 (Date rec'd by registrar) (b) 30 Sept 47

Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1947, at 9:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/8 1947 to 9/29 1947 and that I last saw him alive on 9/29 1947

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Arteriosclerotic C-V disease	
Due to	
Other Conditions Post operative pneumonia (Include pregnancy within 3 months of death)	
Date of operation Sept 47	
Major findings of operation: Benign Prostatic Hypertrophy	
of autopsy: Arteriosclerosis	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. L. Morton M. D.
Address Church Home & Hosp. Date signed 30 Sept 47

X

G55567

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 E

G55567 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1431 andre St
(c) Hospital or institution:
V
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Hopkins

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1431 Andre St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Fredericka Kovak

3 (b) If veteran, name war no

3 (c) Social Security Account No. no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Joseph F Kovak

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 10 1895

8. AGE: Years	Months	Days	If less than one day
51	11	18	hr. min.

9. Birthplace Harford (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Harford

MOTHER
14. Maiden Name Unknown
15. Birthplace Harford

16 (a) Informant Elizabeth Coyle (Daughter)
(b) Address 1520 E Lorraine

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/1/47 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Perkins Highway

18 (a) Funeral director Chas F Dill
(b) Address 1501 E Fort Ave.

19 (a) 1947 (Date rec'd by registrar) Farrington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1947, at 1.45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 27 1947 to Sept 27 1947, and that I last saw her alive on Sept 26 1947.

Immediate cause of death	Duration
Carcinoma of Sigmoid and colon	5 mo
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J F A Stevens M. D.
Address 2818 Harford Ave Date signed 9-29-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every question must be answered. Information should be complete and correct as far as known. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

VS 3

G55568 BALTIMORE CITY HEALTH DEPARTMENT X. G55568
CERTIFICATE OF DEATH 132 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County.....
(c) City or town Freeport L.I. (If outside city or town limits, write RURAL and give town)
(d) Street No. 65 Potterfield Pl. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Corinne Sales Dooley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife James F.

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 9-20-89

8. AGE: Years 58 61 | Months | Days 10 | If less than one day ..... hr. ..... min.

9. Birthplace Ky. Louisville (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Adolphe Sales
13. Birthplace Ky. Louisville

MOTHER 14. Maiden Name Rachel Levy
15. Birthplace England

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 2 47 (month) (day) (year)
(c) Cemetery or crematory.....
Location Far Rockaway N.Y.

18 (a) Funeral director Harry Schuchman & Son
(b) Address 1904 Eutaw Place

SEP 20 1947 (Date rec'd by registrar) (b) Wilmer Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 1947 at 10.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 14 1947 to Sept 30 1947, and that I last saw h[illegible] alive on Sept 30 1947.

Immediate cause of death	Duration
Uremia	[illegible]
Due to Congenital polycystic kidneys	
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy Congenital polycystic kidneys

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature H H Markley M. D.
Address Johns Hopkins Hosp. Date signed 9/30/47

55569

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117A

G55569 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel Co.
(c) City or town Millersville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Joyce

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife ?

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 7/12/79

8. AGE: Years	Months	Days	If less than one day
68	2	17	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Fisherman

11. Industry or business

FATHER
12. Name Richard Joyce
13. Birthplace Maryland

MOTHER
14. Maiden Name Marguerite ?
15. Birthplace Maryland

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/3/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Glenwood Md

18 (a) Funeral director T. B. Hardesty & Son
(b) Address Glenwood Md

19 SEP 30 1947 (Date rec'd by registrar) Courtesy for Williams M.E. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/29 1947, at 6:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/25 1947, to 9/29 1947, and that I last saw him alive on 9/29 1947.

Immediate cause of death	Duration
cerebral embolus + heart failure	? 6 hrs
Due to arterio-sclerosis generalized	5 yrs.
Due to	
Other Conditions Auto-pharynx abscess	3 mos.

(Include pregnancy within 3 months of death)

Date of operation June 23, 1947

Major findings of operation: gastric ulcer

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R Bayne Higgins M.D.

Address Johns Hopkins Hospital Date signed 29 Sept 47

X

Dr. Hornstein 733 Ausgusta St 21783

G55570

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83A

G555570 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information shown is of utmost importance. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey st
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 919 N. Eden st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas W. Holzner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 16th 1865

8. AGE: Years	Months	Days	If less than one day
82	8	13	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Building

FATHER
12. Name Chas. Holzner
13. Birthplace Germany

MOTHER
14. Maiden Name Magdelena Kraus
15. Birthplace Germany

16 (a) Informant Minnie Holzner
(b) Address 919 N. Eden st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/1/47 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul st

19 SEP 30 1947 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29th 1947, at 1a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21 1947, to Sept 28 1947, and that I last saw h/m alive on Sept 28 1947.

Immediate cause of death	Duration
Acute cerebral Hemorrhage	
Due to Ch arteriosclerosis	
Due to Ch Hypertention	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. H. Hornstein M. D.
Address 733 Ausgusta st Date signed 9/30/47

Huntington Williams, M.D.

G55571 BALTIMORE CITY HEALTH DEPARTMENT G55571
Registered No.

CERTIFICATE OF DEATH 467

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4616 Arabia Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4616 Arabia Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard J. Getz

3 (b) If veteran, name war

3 (c) Social Security Account No. 578-07-7675

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Grace Getz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 31st 1904

8. AGE: Years	Months	Days	If less than one day
43	30	28	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Bookbinder
11. Industry or business Washington D.C Phonograph Co

FATHER
12. Name John A. Getz
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary Barthel
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Grace Getz
(b) Address 4616 Arabia Ave

17 (a) Burial (b) Date thereof 10/3/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) SEP 30 1947 (b) Huntington Williams, Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29th 1947 at 3 50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-29 1947 to 9-29 1947 and that I last saw h~~e~~ alive on 9-29 1947.

Immediate cause of death	Duration
Carcinoma of Liver	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lewis J. McGrath
Address 2876 E. Chase St. Date signed 9/30/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be answered. If any item is correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

G55572 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Paul & Mt. Royal Ave.
(c) Hospital or institution: St. Paul Apartments

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 101 E. Mt. Royal Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Williams Vlahakis

3 (b) If veteran, name war: World War 1
3 (c) Social Security Account No.: 157-10-1187

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna Callas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 20, 1895

8. AGE: Years 52 | Months 5 | Days 10 | If less than one day ____ hr. ____ min.

9. Birthplace: Lparta Greece (Town, county, and state)
10. Usual Occupation: Waiter
11. Industry or business: Unemployed

FATHER
12. Name: Louis Vlahakis
13. Birthplace: Greece

MOTHER
14. Maiden Name: Harriet Spiridakos
15. Birthplace: Greece

16 (a) Informant: Mrs. Anna Vlahakis
(b) Address: 101 E. Mt. Royal Avenue

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct. 1, 1947 (month) (day) (year)
(c) Cemetery or crematory: Arlington Cem
Location: Jersey City, N. J.

18 (a) Funeral director: William Cook, Inc.
(b) Address: 1217 St. Paul Street

19 (a) SEP 30 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 19 , at 1130 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 9 19 46 to Date 19 , and that I last saw h. in alive on Sept 3 19 47.

Immediate cause of death: Carcinoma - Lung — Duration: 1 year
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation: March 1947
Major findings of operation: Inoperable carcinoma of lung
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Alan Bernstein M. D.
Address: 1109 N Calvert St Date signed 9/30/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G55573 G55573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131A

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2107 Westwood Ave
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2107 Westwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Applefeld

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1855

8. AGE: Years 92 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Isaac Applefeld
13. Birthplace Russia

MOTHER
14. Maiden Name Bessie ?
15. Birthplace Russia

16 (a) Informant Harry Applefeld
(b) Address 2107 Westwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 1, 1947 (month) (day) (year)

(c) Cemetery or crematory Ritz Chaim Cemetery
Location Hebrew Washington Road Cem

18 (a) Funeral director Sol Levinson Bros
(b) Address 1124-1126 W North Ave

19 (a) 1947 (Dated) (b) Huntington Williams, M.D. Registrar
(Rec'd by registrar)

MEDICAL CERTIFICATION 4.30

20. DATE OF DEATH September 30 1947 at P/M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/27 1947 to 9/30 1947, and that I last saw h[illegible] alive on 9/30 1947

Immediate cause of death	Duration
a Acute Cardiac Dilatation	2 days
Due to Hypertension & Cardiac Renal Vascular Disease	5 years
Due to Generalized Arteriosclerosis	20 "
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M.D.
M. D.
Address 2316 Eutaw Pl Date signed 9/30/47

VS 150

4. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be answered. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

A55-406 / 116

G55574
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Belcamp.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Belcamp Hotel.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Linda Louise Spaulding

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-28-47

8. AGE: Years | Months 34 | Days 2 | If less than one day: hr. min.

9. Birthplace Md. Harford Co
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Merton Spaulding
13. Birthplace N.Y.

MOTHER
14. Maiden Name Joan Plunkett
15. Birthplace N.Y.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof OCT 2 1947 (month) (day) (year)
(c) Cemetery or crematory Darlington
Location Darlington, Md

18 (a) Funeral director Leila Patterson & Son
(b) Address Cherryville, Md.

19 (a) OCT 1 1947 (Date received by registrar) Huntington Williamsport

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29- 1947 at 11 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-1- 1947 to 9-29-1947 and that I last saw her alive on 9-29-1947.

Immediate cause of death: Septicaemia — Duration

Due to: abscess of ovary, post-puerperal

Due to: operation for tubo-ovarian abscess

Other Conditions: fistula

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J M Edmonds M. D.
Address JHH Date signed 9-30-47

X

G55575

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G G55575 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave & Madison St
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 431 E. Lorraine Ave #18
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Hugh Moon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace Staunton Va
(Town, county, and state)

10. Usual Occupation Chemist

11. Industry or business Peter Dist Co Distillery

FATHER
12. Name John A Moon
13. Birthplace Va

MOTHER
14. Maiden Name Ada A Seibert
15. Birthplace Va

16 (a) Informant Luther A Barton
(b) Address 362 Ruby St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/1/47 (month) (day) (year)

(c) Cemetery or crematory Thornrose
Location Staunton Va

18 (a) Funeral director Wilson & Son
(b) Address 12 N St Paul St

19 Oct 1 1947 Date filed by registrar Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 Sept 1947, at 4:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 30 Sept 1947 to 30 Sept 1947, and that I last saw him alive on 30 Sept 1947.

	Duration
Immediate cause of death: Coronary occlusion	1 day
Due to: Hypertensive cardio-vascular disease	?
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Allan Aper M. D.
Address Md Gen. Hosp Date signed 30 Sept 47

VS 130

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

55576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓108

G55576

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore
(b) Street address 327 N. Schroeder St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 d
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 327 N. Schroeder
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James E. Donnican

3 (b) If veteran, name war

3 (c) Social Security Account No. 2/2-14-8191

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Mary J. Donnican

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 15 - 80

8. AGE: Years 67 | Months 5 | Days 14 | If less than one day hr. min.

9. Birthplace Norfolk Va (Town, county, and state)

10. Usual Occupation Lab

11. Industry or business

FATHER
12. Name Jno Donnican
13. Birthplace Kentucky

MOTHER
14. Maiden Name Sarah Cash
15. Birthplace Blue Ridge Va

16 (a) Informant Mary J. Donnican
(b) Address 327 N. Schroeder

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/3/47 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location 4 & Co. Md

18 (a) Funeral director Met. Funeral Home Inc
(b) Address 627 N. Mount St

19 Date rec'd 1947 (Huntington Williams, M.D. Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/29 19 47, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/24 19 47 to 9/29 19 47, and that I last saw h. alive on 9/29 19 47

Immediate cause of death Lobar Pneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Peter Roberts M.D.

Address 26 [illegible] 1947 Date signed 9/29/47

55577.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G55577
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Jenkins Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County Frederick
(c) City or town Mt. St. Marys College
(If outside city or town limits, write RURAL and give town)
(d) Street No. Emmitsburg Md.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. Philip Gallagher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1870

8. AGE: Years 77 | Months 3 | Days 24 | If less than one day hr. min.

9. Birthplace Coaldale, Penna.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Daniel Gallagher
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine McCaffery
15. Birthplace Ireland

16 (a) Informant Sister Winifred Kerwin
(b) Address Jenkins Memorial

17 (a) Burial (Burial, cremation, or removal) Baltimore (b) Date thereof (month) (day) (year) Md. Oct 4 1947

(c) Cemetery or crematory Mount St. Mary's
Location Emmitsburg, Md.

18 (a) Funeral director E. L. Allison
(b) Address Emmitsburg, Md.

OCT (a) 1 1947 (Date rec'd by registrar) Hagerstown Williamsport Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given. Be sure to write the causes of death clearly and legibly. correct age is especially important. Physicians: please write

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/1/1947 at 2:AM M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/8 1947 to 10/1/1947 and that I last saw h[illegible] alive on 9/30 1947

Immediate cause of death – Cardiac failure — Duration

Due to Hypostatic C.V.D.

Due to Senile Dementia

Due to Bronchopneumonia Lobar

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place) MINTZER
(e) Means of injury

23. Signature Donald W Mintzer
Address St Cyprian Hosp Date signed 10/1/47

VS 150

55578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

G55578 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be answered or "unknown" supplied, if correct ago is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1535 McKean Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 1535 McKean Ave.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Balto., Md.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK F. WAGNER

3 (b) If veteran, name war: None
3 (c) Social Security Account No. no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife: Mary E. Wagner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1888

8. AGE: Years	Months	Days	If less than one day
58	11	0	hr. min.

9. Birthplace Pikesville, Md.
(Town, county, and state)
10. Usual Occupation Motorman Retired
11. Industry or business Balto. Transit Co.

FATHER
12. Name Frank F. Wagner
13. Birthplace Pikesville, Md.

MOTHER
14. Maiden Name Mary Colley
15. Birthplace Pikesville, Md.

16 (a) Informant Mrs. Evelyn Schultheis
(b) Address 1535 McKean Ave.

17 (a) Burial (b) Date thereof 10/1/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Stone Chapel
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS INC.
(b) Address North & Pa. Aves. Balto. 17, Md.

19 (a) Oct 1 1947 (b) Huntington Williams
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH Sept. 27, 1947 19 at 7:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1947 to Sept. 27 1947.
and that I last saw h live on Sept. 27 19 47.

Immediate cause of death	Duration
Cardiac decompensation	Time
Due to Rheumatic C-V disease	
Mitral Stenosis	
Due to Arteriosclerotic Fibrillation	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Stranger
Address 1428 Kenyon Rd Date signed 9-29-47.

655579

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

655579 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore St (If outside city or town limits, write RURAL and give town)
(d) Street No. 502 Wyeth Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John F. Russell

3 (b) If veteran, name war: Spanish American
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Georgia Russell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26, 1869

8. AGE: Years 78 | Months 4 | Days 2 | If less than one day ____hr. ____min.

9. Birthplace Balto. Maryland (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name John W. Russell
13. Birthplace Maryland

MOTHER
14. Maiden Name Carolina Coe
15. Birthplace Maryland

16 (a) Informant Carrie Erwin
(b) Address 502 Wyeth St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 1, 47 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Frederick Ave.

18 (a) Funeral director Joseph T. Gardner, Jr.
(b) Address 414 N. Franklintown Rd.

19 (a) OCT 1 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 1947 at 4:05 P M

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earle Royer M.D. Medical Examiner
Date signed 9-29-47

VS 191

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

655580 655580

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. 655580

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be answered; if none, write NONE. Physicians: please write the causes of death clearly and legibly. If correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1425 N. Gay St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1425 N. Gay St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie May Andrew

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Harry A. Andrew
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Dec - 15 - 1883

8. AGE: Years	Months	Days	If less than one day
63	9	15	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Herman Pelton
13. Birthplace Germany

MOTHER
14. Maiden Name Lilly Briscoe
15. Birthplace Va

16 (a) Informant Harry A. Andrew
(b) Address 1425 N Gay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-3-47 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Mt Olivet Ave

18 (a) Funeral director John C. Miller Inc
(b) Address 2435 E. Oliver St

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 30 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1947 to Sept 30 1947, and that I last saw deceased alive on Sept 25 1947.

Immediate cause of death	Duration
Carcinoma of Lungs Metastasis	2 Mos.
Due to	
Due to	
Other Conditions Breast operation 2 years ago (Include pregnancy within 3 months of death)	2 yrs approx.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Janet Fisher M. D.
Address 1823 N. Monroe St. Date signed 9/30/47

G55581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 931

Registered No. G55581

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: Elmhurst Nursing Home 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 1708 Eutaw Place (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore, Md. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie S. Bates

3 (b) If veteran, name war	3 (c) Social Security Account No.
***	***

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FM	W	Widowed

6 (b) Name of husband or wife Frank E. Bates
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 24, 1860

8. AGE: Years	Months	Days	If less than one day
86	10	5	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Ralph Smith
(b) Address Waterloo Ave. Ellicot City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/47 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Baltimore

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

OCT 1 1947 (Date rec'd by registrar) Hunting for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29 1947, at 7:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 5 1946 to Sept 29 1947. and that I last saw her alive on Sept 28 1947.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Advanced Arteriosclerosis

Due to Cardio-vascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lucy Jacobs M.D.
Address 1700 Eutaw Place Date signed Sept 30-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered or the words "unknown" or "none" inserted as the case may be. Be sure that the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X (17)

G55582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G55582

1. PLACE OF DEATH: 138
(a) Baltimore City, Maryland
(b) Street address 138 South Louden
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 70
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 138 South Louden
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Burgess

3 (b) If veteran, name war None

3 (c) Social Security Account No. 216-10-2055

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Adelaide J. Burgess

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 30, 1883

8. AGE: Years 63 | Months 10 | Days 29 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business E. W. Kemp

FATHER
12. Name William Burgess
13. Birthplace Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace Maryland

16 (a) Informant Adelaide J. Burgess
(b) Address 138 S. Louden Ave.

17 (a) Burial (b) Date thereof 10-1-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Howard County, Md.

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Ave.

19 (a) OCT 1 1947 (b) Courtesy of Baltimore, Md.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 | 28 | 47 19..., at 5:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Hrs death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury

23. Signature John R. Evans M.D.
Medical Examiner.
Date signed 9/28/47

correct age is especially important. Physicians: please w

G55583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 168

Registered No. G55583

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1233 Myrtle Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Norman D. Walker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 2, 1917

8. AGE: Years: 29 | Months: 11 | Days: 28 | If less than one day ..... hr. ..... min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name: Douglas Walker
13. Birthplace: Va.

MOTHER — 14. Maiden Name: Gladys Powell
15. Birthplace: Va.

16 (a) Informant: Mrs. Alma Burley
(b) Address: 1737 N. Carey st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10/2/47 (month) (day) (year)
(c) Cemetery or crematory: Empona
Location: Lawrenceville, Va.

18 (a) Funeral director: Geo. B. Kelbaugh
(b) Address: 1303 Pleasant St.

19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151 a ,,,,8

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-30-1947, at 1-35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Fractured skull
Intracranial Hemorrhage
Due to Abscess of brain
Acute Meningitis
Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9/20/47 8:18 P.M. 4-1
(b) Where did injury occur Baltimore & Frederick Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Knocked off street-Car due to altercation

23. Signature Thomas J. Mueller M.D. Medical Examiner.
Date signed 9-30-47

G55584

BALTIMORE CITY HEALTH DEPARTMENT ✓ G55584 Registered No.

CERTIFICATE OF DEATH 130

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 805 Whatcoat St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 805 Whatcoat St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard Porter
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/12/1940

8. AGE: Years	Months	Days	If less than one day
7	1	16	hr. min.

9. Birthplace Balto, Md (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John Porter
13. Birthplace Md

MOTHER
14. Maiden Name Martha Dorsey
15. Birthplace Md

16 (a) Informant John Porter
(b) Address 805 Whatcoat St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 2, 1942 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md.

18 (a) Funeral director Geo. H. Kelson
(b) Address 303 Preasman Bldg

19 (a) [illegible] (Date rec'd by registrar) (b) [illegible] (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 1942, at 5:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 17 1942 to Sept. 28 1942 and that I last saw h[illegible] alive on Sept 17 1942

Immediate cause of death	Duration
Tuberculosis	One
Due to	
Due to	
Other Conditions: Marked Malnutrition	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. W. Anderson, M. D.
Address 436 W. Lanvale Date signed 9-30-42

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131A

Registered No. G55585

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry of information should be typewritten. Physician: please write the cause of death clearly and legibly. Be sure that correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1631 N. Calhoun St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1631 N. Calhoun St (If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country

3 (a) **FULL NAME** Herbert Williams

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Bertha Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30, 1876

8. AGE: Years 71 | Months 1 | Days 28 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Contractor

FATHER 12. Name Lewis Williams

13. Birthplace Virginia

MOTHER 14. Maiden Name Harriett Toney

15. Birthplace Virginia

16 (a) Informant Emma Jefferson

(b) Address 1631 N. Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-1-47 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn.

Location 2nd

18 (a) Funeral director George E. Nelson

(b) Address 2303 Presstman St

19 (a) 1 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-25 1947, at 10:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1- 1947 to 9-25 1947 and that I last saw h alive on 9-27, 1947.

Immediate cause of death Cardio-Renal-Vascular Disease — Duration 2 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George C. Page M. D.
Address 1516 N. Mount St (17) Date signed 10-1-47

VS 150

C55586

CWK-113791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

J C55586 74A

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 Madison Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Geraldine Paster

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13-1929

8. AGE: Years 18 | Months 5 | Days 16 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Alphonso Paster (D)
13. Birthplace Maryland

MOTHER
14. Maiden Name Bertha Hughes
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 3, 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk
Location Baltimore Co. Md.
18 (a) Funeral director Mrs. Geo. H. Holland
(b) Address 1631 Druid Hill Ave
19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

OCT 1 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 29 19 47, at 7:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 13 19 47 to Sept. 29 19 47, and that I last saw her alive on Sept. 29 1947.

Immediate cause of death	Duration
Secondary Shock	10 mins
Secondary Anemia	5 months
Due to Subleukemic Leukemia	5 months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Sept 26, 1947
Major findings of operation: Biopsy of Bone Marrow - Negative
of autopsy: Leukemia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hosps. Date signed 9-30-47

X

55587

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G55587 Registered No.

93D

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1424 Argyle Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1424 Argyle Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Oswald HARMON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Susan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1885

8. AGE: Years 61 | Months 11 | Days 29 | If less than one day ___ hr. ___ min.

9. Birthplace Crisfield, Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name George Harman
13. Birthplace Crisfield Md.

MOTHER 14. Maiden Name Carrie Fricks
15. Birthplace Crisfield Md.

16 (a) Informant Susan Harman
(b) Address 1424 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 4, 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk
Location Baltimore Co. Md.

18 (a) Funeral director Wm. Law. By Hall & Sons
(b) Address 1691 Druid Hill Ave.

19 OCT 1 1947 (Date rec'd by registrar) (b) Huntington Williams, Jr. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH September 30 1947, 8:55 A.M.

21. I certify that I took charge of the remains described above, held an INSPECTION (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

Signature George F. Merrill M.D. Medical Examiner.

Date signed 9/30/47

correct age is especially important. Physician: please write the causes of death clearly and legibly.

55588

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 655588

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 121 N Duncan St

(c) Hospital or institution:

b

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 121 N Duncan
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Catherine Gross~~ CATHERINE GROSS

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-16-5795

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: WIDOWED

6 (b) Name of husband or wife: FREDERICK GROSS

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1908

8. AGE: Years 39 | Months 12 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation HOUSE-WORK

11. Industry or business AT HOME.

FATHER

12. Name WILLIAM SCHENNING

13. Birthplace BALTO. MD.

MOTHER

14. Maiden Name UNKNOWN

15. Birthplace BALTO., MD.

16 (a) Informant CHARLES GROSS (SON)

(b) Address 3608 FAIT AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-1-47 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart Gem
Location Harmon Hill Rd.

18 (a) Funeral director Charles S. Zeiler.

(b) Address 901 S. Conkling St.

19 (a) 1947 (Date rec'd by registrar) Washington Wilkins, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 28/47 19 10.30a at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 27, 19 47 to Sept. 28 19 47, and that I last saw h alive on Sept 28 19 47

Immediate cause of death	Uraemia	24 hrs
Due to	Chr. Nephritis + Hypertension	?
Due to		
Other Conditions		

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature [illegible], M. D.

Address 700 N. Rath Date signed 9/29/47

PLEASE WRITE PLAINLY, WITH INK AND FULL NAMES. Please write the causes of death clearly and legibly. correct age is especially important. Physicians: please write

V S 150

X

G55589 437323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ X G55589 Registered No. 157E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ohio. (b) County
(c) City or town Steubenville. (If outside city or town limits, write RURAL and give town)
(d) Street No. 204 Opal, Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Patricia Gasaway

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-19-41

8. AGE: Years	Months	Days	If less than one day
6	4	11/24	hr. min.

9. Birthplace Ohio (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Robert Gasaway
13. Birthplace W. Va.

MOTHER
14. Maiden Name Emma Eggett
15. Birthplace Ohio

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-1-47 (month) (day) (year)
(c) Cemetery or crematory
Location Martins Ferry, Ohio

18 (a) Funeral director Jones & Johnston
(b) Address North & Penny Aves

OCT 1 1947 Huntington Williams, W.Va. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. - 1 - 1947, at 12 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-29- 1947 to 10-1- 1947, and that I last saw her alive on 10-1- 1947.

Immediate cause of death	Duration
Intracranial thrombosis	
Due to Post-operative Petrolazy & Fallot	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 9/30/47
Major findings of operation: Polycystic Stenosis Pulmonic
of autopsy: Intra Cr. Thrombosis - Stenosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature David C. Sabiston Jr.
Address Johns Hopkins Hospital Date signed 10/1/47 M/D

PLEASE WRITE PLAINLY, with unfading ink. Use typewriter if possible. Do not use pencil. Be sure to write the causes of death clearly and legibly. Be sure that the information given for each item is complete and correct as far as known. Be sure to write in the space provided for each item. Be sure that the age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

655590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

✓ 655590 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Frederick Ave
(c) Hospital or institution: Colonial Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2928 W. Mosher St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick E. Wille

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Widower

6 (b) Name of husband or wife: Lola Lucia M. Wille
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1866

8. AGE: Years	Months	Days	If less than one day
81	4	6	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Baker

FATHER
12. Name Jacob Wille
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina Stauben
15. Birthplace Germany

16 (a) Informant John H. Wille
(b) Address 2928 W. Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 1/47. (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Little
(b) Address 4101 Edmondson Ave.

19 (a) (Signature of registrar) (b) Registrar
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/28/47. 19 , at 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1945 to Sept 28 1947.
and that I last saw him alive on Sept 26 1947.

Immediate cause of death Myocardial degeneration
acid insufficiency.
Arterio sclerotic type of Int hemd
Due to with congestive failure
Due to Generalized arterio sclerosis.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
Several years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Michel M. D.
Address 2901 Edmondson Ave Date signed Sept 30 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

Tavares ✓

G55591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G55591 Registered No. L 47 47

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2128 Druid Hill ave.
(c) Hospital or institution:
14 3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2128 Druid Hill ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kathryn N. Tavares

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race colored

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Francis Tavares

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Mar 4 1905

8. AGE: Years 42 | Months 6 | Days 24 | If less than one day ... hr. ... min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Joseph Nicholas

13. Birthplace Canada

MOTHER 14. Maiden Name Kitty Madden

15. Birthplace Balto. Md.

16 (a) Informant Ellen Dutton

(b) Address 2115 Druid Hill ave.

17 (a) Burial (b) Date thereof 10/4/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Zion

Location Balto. Md.

18 (a) Funeral director Wm. J. Chatman Jr

(b) Address 1701 McCulloh St. Balto. Md

19 (a) 1947 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 1947 at 11:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 11 1946 to Sept. 30 1947 and that I last saw h.e.r alive on 9/30 1947

Immediate cause of death Pneumonia, Bronchial — Duration 9 days

Due to Asthma

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R B Lightstone M.D.

Address 501 Cherry Hill Rd. Date signed 9/30/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Be sure to write the causes of death clearly and legibly. Exact age is especially important. Physicians: please write

G55592

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

✓ G55592 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Howard and Madison St.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 832 N. Eutaw St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Irving Burton Smoot

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-14-8236

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Sarah R Smoot

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 24 1873

8. AGE: Years 73 | Months 11 | Days 5 6 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation None

11. Industry or business Prisoner said

FATHER
12. Name Burton Smoot
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Baldwin
15. Birthplace Virginia

16 (a) Informant Mrs. Stanley Astle
(b) Address 13 yr James St

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT. 2 1947 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location BALTIMORE

18 (a) Funeral director FRED. A. COLE
(b) Address 1200 W. LOMBARD

19 (a) [illegible] 1947 (Date rec'd by registrar) (b) [illegible] Williamsport Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-30 1947, at 2:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-29 1947 to 9-30 1947 and that I last saw h im alive on 9-30 1947.

Immediate cause of death Respiratory and cardiac failure — Duration

Due to Chronic cholangeitis and cholelithiasis with

Due to possible Ca of Pancreas

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Carlton Brimafield M. D.
Address Maryland General Hospital Date signed 9-30-47

VS 150

G55593

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G55593

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Lea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 903 Morris St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Watson Tillman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1910

8. AGE: Years	Months	Days	If less than one day
37	8	6	hr. min.

9. Birthplace Culpeper, Virginia (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name James Ware
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary ?
15. Birthplace

16 (a) Informant Freeman Tillman
(b) Address 903 Morris St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-2-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (Date rec'd by registrar) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28th 1947 at 1 40 A.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Myocardial Degeneration

Due to

Other Conditions Pediculosis, Marked Debilitation

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D. Medical Examiner.

Date signed 29 Sept 47

VS 151

Correct age is especially important. Physicians: please write

G555948 BALTIMORE CITY HEALTH DEPARTMENT G955594

CERTIFICATE OF DEATH

74A

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 9 days
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 1808 Bank Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: George Andrew Rozga

3 (b) If veteran, name war	3 (c) Social Security Account No.
WW 2	---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 10, 1921

8. AGE: Years	Months	Days	If less than one day
26	5	19	....hr. ....min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual Occupation: Machinist
11. Industry or business:

FATHER
12. Name: John Rozga
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Anna Wrzediski
15. Birthplace: Baltimore, Md.

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (b) Date thereof 10/4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory: St. Stanislaus
Location: Mt. Carmel Road

18 (a) Funeral director: M.F. Sadowski & Sons
(b) Address: 1808 Eastern Avenue

19 (a) Date rec'd 1947 Thurlington Williams, M.D. Registrar
(Registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 29 19 47, at 10:42 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 20 1947, to Sept. 29 1947, and that I last saw him alive on Sept. 29 19 47.

Immediate cause of death: Acute leukemia — Duration: 26 days

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sp. Surgeon
Address: Clinical Director Date signed: 9/29/47 M.D.

G55595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G55595 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. ENTRY must be made for every item of information. If unknown or if not applicable, write the word. Physicians: please write the causes of death clearly and legibly. Underline the cause to which death should be charged statistically. Please report correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2506 W. Lafayette Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2506 W. Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KATIE E. POSTHER

3 (b) If veteran, name war –

3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife John H. Posther
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) Jan. 30, 1868

8. AGE: Years	Months	Days	If less than one day
79	7	29	hr. min.

9. Birthplace Charles Town, W. Va.
(Town, county, and state)
10. Usual Occupation –
11. Industry or business

FATHER
12. Name Francis Allen
13. Birthplace Unknown

MOTHER
14. Maiden Name Frances Everhart
15. Birthplace Unknown

16 (a) Informant Mr. John H. Posther
(b) Address 2506 W. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/47 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 1 1947 (Date rec'd by registrar) Twentington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29, 1947, at 11:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1947 to Sept. 1947, and that I last saw her alive on Sept. 29 1947.

Immediate cause of death	Duration
Arteriosclerotic Cardio-Vascular Disease	
Due to	
Due to	
Other Conditions Senility	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clarence Loughlin M. D.
Address 400 N. Payson St. Date signed 10/1/47

G55596 | BALTIMORE CITY HEALTH DEPARTMENT ✓ | G55596 Registered No.

CERTIFICATE OF DEATH 74A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Every item is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave. & Madison St.
(c) Hospital or institution: Maryland General Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 633 Woodington Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine G. Flagler

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Jeff C. Flagler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 1, 1885

8. AGE: Years: 62 | Months: 5 | Days: 0 | If less than one day: hr. min.

9. Birthplace: Albany, N. Y.
(Town, county, and state)

10. Usual Occupation: housewife

11. Industry or business:

FATHER
12. Name: Joseph Canavan
13. Birthplace: Albany, N. Y.

MOTHER
14. Maiden Name: Gertrude Gleason
15. Birthplace: Albany, N. Y.

16 (a) Informant: Mr. Jeff C. Flagler
(b) Address: 633 Woodington Rd.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/2/47 (month) (day) (year)
(c) Cemetery or crematory: Albany Rural Cem.
Location: Albany, N. Y.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar: Washington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 Oct 1947, at 7:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 13 July 1947 to 1 Oct 1947, and that I last saw h... alive on 1 Oct 1947.

Immediate cause of death: Chronic myelogenous leukemia — Duration: 3 mo.

Due to:

Due to:

Other Conditions: Anemia.
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature A. Allan Gray M.D.

Address Md. Gen. Hosp. Date signed 1 Oct 47

G55597 X ✓ G55597

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92A

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Rural - Perry Hall
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baker's Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nicholas Regert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife Eva Regert

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) 9-23-1885

8. AGE: Years 62 | Months 0 | Days 7 | If less than one day: hr. min.

9. Birthplace Austria-Hungary (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Balto. Transit Co.

FATHER
12. Name Joseph Regert
13. Birthplace Austria-Hungary

MOTHER
14. Maiden Name Unknown
15. Birthplace Austria-Hungary

16 (a) Informant Eva Regartt
(b) Address Bakers Lane, Perry Hall

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 10/4/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md.

18 (a) Funeral director Loraine Funeral Home
(b) Address 7401 Belair Rd. Balto. 6, Md.

19 (a) OCT 1 1947 (Date received by registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-30 1947 at 6:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-16 1947 to 9-30 1947 and that I last saw him alive on 9-30 1947

Immediate cause of death: Arteriosclerotic heart disease — Duration:

Due to:

Due to:

Other Conditions: Bronchopneumonia, St Louis Encephalitis

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: CORONARY ARTERIOSCLEROSIS, CALCIFICATION, AORTIC VALVES

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert E Mays M. D.

Address St Joseph's Hosp. Date signed 9-30-47

55598

CWK-114113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ G55598 Registered No. 13B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 1½ Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Chase (If outside city or town limits, write RURAL and give town)
(d) Street No. Chase P. O. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alberta White (Maiden name Alberta Whitfield)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Kermit
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 5-1925

8. AGE: Years	Months	Days	If less than one day
24	7	25	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Sidney Whitfield
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Bradley
15. Birthplace Virginia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof 10 3 47 (month) (day) (year)
(c) Cemetery or crematory Suffolk Virginia
Location

18 (a) Funeral director Watts Bros. Inc
(b) Address 13 W. Hamburg St

19 (a) OCT 1 1947 (Date received by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 30 1947, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 27 1947, to Sept. 30 1947, and that I last saw h er alive on Sept. 30 1947.

Immediate cause of death	Duration
Respiratory failure	5 da
Due to Tuberculosis of lung	9 mo
for advanced	
Due to	
Other Conditions Tuberculosis peritonitis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: see above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph J Bowen Jr M. D.
Address 4 E Lexington St Date signed 9-30-47

PLEASE WRITE CLEARLY, using pen and ink and write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G55599 — BALTIMORE CITY HEALTH DEPARTMENT — G55599

Frangione ✓

BC# 990692 — CERTIFICATE OF DEATH — 161 C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information known or obtainable must be entered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 6 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 724 Kelsin ave
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Frangione

3 (b) If veteran, name war No
3 (c) Social Security Account No. None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-30-47

8. AGE: Years | Months | Days | If less than one day: 6 hr. 0 min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Robert Frangione
13. Birthplace N. Y. State

MOTHER
14. Maiden Name Dorothy
15. Birthplace N. Y. State

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-2-47 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Baltimore

18 (a) Funeral director George A Farley
(b) Address Fulton Ave & Fayette St

19 (a) 1947 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-30-47 19..., at 8:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-30 1947 to 9-30 1947 and that I last saw h... alive on 9-30 1947.

Immediate cause of death Asphyxia Duration: Few min.

Due to Atelectasis 2 hrs.

Due to Pos. Cerebro-Vascular accident

Other Conditions Erythroblastosis Congen.

(Include pregnancy within 3 months of death)
Date of operation 9-30-47
Major findings of operation: Exchange transfusion
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William D. Gentry M. D.
Address Mercy Hosp. Date signed 9-30-47

VS 150

G55600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 C

G55600 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) bdup
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 614 Edgewood Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lula Kilgore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Chas. V. Kilgore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan 30 1878

8. AGE: Years 69 | Months 8 | Days 21 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business —

FATHER 12. Name Augustus Harding
13. Birthplace Md.

MOTHER 14. Maiden Name Lula Thomas
15. Birthplace Md.

16 (a) Informant Lillian Massey
(b) Address 614 Edgewood St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Springfield
Location Sykesville Md.

18 (a) Funeral director Harry West
(b) Address Sykesville Md

19 (a) 2 1947 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

correct age is especially important. Physicians: please write

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1, 1947 at 10 15 A.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to h[illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull, Intracranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-24-47. 7 30 P. M. 6-8
(b) Where did injury occur? Edmondson Avenue & Franklin Streets
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by motor

23. Signature [signature] M.D. Medical Examiner.
Date signed 10-1-47

C55601 C55601

55601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. C55601

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1118 Forrest st
(c) Hospital or institution: 10

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1118 Forrest St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jesse Lee Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

10/1/47

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 October 1947, at 9A. M

4. Sex	5. Color or race	6 (a) Single, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Sarah May Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 29th 1858

8. AGE: Years	Months	Days	If less than one day
89	5	2	hr. min.

9. Birthplace Patapsco, Carroll Co. Md. (Town, county, and state)

10. Usual Occupation Retired R.R Conductor

11. Industry or business Western Md R.R.

MOTHER FATHER

12. Name Reuben A. Smith

13. Birthplace Carroll Co. Md.

14. Maiden Name Anne R. Taylor

15. Birthplace Carroll Co. Md.

16 (a) Informant Sarah L. Smith

(b) Address 1118 Forrest St

17 (a) Burial (b) Date thereof 10/4/47 (Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Bethel

Location Carroll Co. Md.

18 (a) Funeral director Williams Cook Inc.

(b) Address 127 St. Paul St.

OCT 2 1947 (Date rec'd by registrar) Huntington Hill

VS 191

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Wm. H. Kammer, Jr. M.D. Medical Examiner.

Date signed 10 Oct. 1947

X

55602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G55602
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Sinai Hospital
(b) Street address Monument & Rutland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Queen Anne's
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Love Point Md
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MRS IDA MARKS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Israel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business House Wife

FATHER
12. Name Samuel Teves
13. Birthplace Russia

MOTHER
14. Maiden Name Rachel ?
15. Birthplace Russia

16 (a) Informant Israel Marks
(b) Address Love Point Md

17 (a) Burial (b) Date thereof Oct 2, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cemetery
Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 47 Oct 2 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1 1947 at 5:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 30 1947, to Oct 1 1947, and that I last saw her alive on Oct 1 1947.

Immediate cause of death	Duration
Cerebro - Vascular accident	
Due to Arteria Sclerosis.	
Due to	
Other Conditions Arteria Sclerotic Cardio-Vascular Disease	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Cerebro-Vascular accident Arteriosclerosis Cardio-Vascular disease

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Allan J. Wolinsky M. D.
Address Sinai Hospital Date signed 10-1-47

83A

55603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G55603
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 1549
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 14

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3923 Fairview (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Shirley Hankin

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-2825

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-11-20

8. AGE: Years 27 | Months 5 | Days 20 | If less than one day hr. min.

9. Birthplace Del (Town, county, and state)

10. Usual Occupation Secretary

11. Industry or business Business

FATHER
12. Name Wm Hankin
13. Birthplace Penna

MOTHER
14. Maiden Name Minnie Fox
15. Birthplace Md.

16 (a) Informant Mrs. Minnie Hankin
(b) Address Same 3923 Fairview ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 2, 1947 (month) (day) (year)
(c) Cemetery or crematory Helen Harvey Rodgers
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-26 W North ave

OCT 2 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-1 1947 10 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-17 1947 to 10-1 1947. and that I last saw h[illegible] alive on 10-1 1947.

Immediate cause of death	Duration
Metastatic CA	2 yrs 2 mos
Due to Breast	
Due to CA of Breast	6 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 9-45
Major findings of operation: CA of Breast
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address Mercy Date signed 10-1-47

VS 150

5604

DR. J. S. BLUM
1206 E. Preston St.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131A

G55604
Registered No.

Please write the causes of death clearly and legibly. Physicians: please state the exact age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1243 ERST Eager St
(c) Hospital or institution: 10-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1243 E. Eager Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Welsh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife William P. Welsh
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 19, 1874

8. AGE: Years	Months	Days	If less than one day
73	6	10	hr. min.

9. Birthplace Washington, D.C.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name John Kelly
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Shay
15. Birthplace Ireland

16 (a) Informant Mr. John E. Welsh
(b) Address 2822 Lake Avenue, 13

17 (a) Burial (b) Date thereof 10-2-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Washington, D.C.

18 (a) Funeral director Leonard J. Ryck
(b) Address 5305 Harford Road, 14

19 (a) 2 1947 Washington, Williams, M.D.
(Date rec'd by Registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29th, 1947, at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 12 1947 to Sept 29 1947. and that I last saw her alive on Sept 29 1947.

Immediate cause of death	Duration
Arteriosclerotic Cardio Vascular renal disease	7
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph S. Blum M. D.
Address 1206 E. Preston Date signed 9/30/47

X

55605

42115-5

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30 C

G55605 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 Carrollton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME David Rowland.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Agnes Rowland

6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) 11-26-81

8. AGE: Years 65 | Months 10 | Days 5 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Works at Spa. Pt.

11. Industry or business

FATHER 12. Name Lindsay Rowland

13. Birthplace Va.

MOTHER 14. Maiden Name Winnie Evans

15. Birthplace Va.

16 (a) Informant Agnes Rowland

(b) Address 1004 N. Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 6 1947 (month) (day) (year)

(c) Cemetery or crematory Greenmount Cem. Balto.

Location Balto. Co. Md.

18 (a) Funeral director Thos. Geo. H. Hyde

(b) Address 1631 Druid Hill Ave.

19 OCT 2 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 — 1947 at 11:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-29- 1947 to 9-30- 1947 and that I last saw him alive on 9-30- 1947.

Immediate cause of death	Duration
Sub-dural hematoma	2 wks
Due to Hypertensive Vascular disease	unknown
Due to	
Other Conditions Late CNS syphilis, treated	unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E. Mason M.D.

Address Johns Hopkins Hosp. Date signed 1 Oct 47

Please write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

655606

JL - 112173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 511

655606 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 241
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1428 Andrew St. ANDRE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stanley Fronkowski (Stanislaw Fronczkowski)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Stella
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1879

8. AGE: Years	Months	Days	If less than one day
68	1	15	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name John Fronkowski
13. Birthplace Poland

MOTHER
14. Maiden Name Josephine Cherry
15. Birthplace Poland

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 3 47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W Orazewski
(b) Address 1930 Eastern Ave

OCT 2 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30, 1947 at 2.45A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1947, to Sept. 30 1947, and that I last saw h in alive on Sept. 30 1947

Immediate cause of death	Duration
Cardiac dilatation	1 month
Due to Generalized Arteriosclerosis	8 years
Due to	
Other Conditions Carcinoma OF Penis (Include pregnancy within 3 months of death)	19 months

Date of operation 9-3-47
Major findings of operation: Ca of Penis
of autopsy: Cardiac dilatation

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. E. Geoff E M. D.
Address 4940 Eastern Ave Date signed 9-30-47

95C

5607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47D

Registered No. G55607

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2329 Eutaw Place
(c) Hospital or institution: 13-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2329 Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If so, name country

3 (a) FULL NAME Gustav Rosenthal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Adele

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Gabriel
13. Birthplace Germany

MOTHER
14. Maiden Name Jeanette
15. Birthplace Germany

16 (a) Informant Adele Rosenthal
(b) Address 2329 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-2-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2100 Eutaw Place

19 (a) OCT 2 1947 (Date received by registrar) (b) Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-1-1947 at 6A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/23 1947 to 9/30/ 1947 and that I last saw him alive on 9/30/ 1947.

Immediate cause of death: Cancer of the lung — Duration: about 6 months

Due to:

Due to:

Other Conditions: and cholecystitis with common cholecystostomy
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Weinberger M. D.
Address 912 Brooks Lane Date signed 10/1/47

G55608

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G55608 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 19-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1305 Booth Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Abraham QUEEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11 6 7

8. AGE: Years 80 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Baltimore, Md (town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name William Queen

13. Birthplace Md

MOTHER 14. Maiden Name Unknown

15. Birthplace Md

16 (a) Informant Mrs Viola Queen

(b) Address 1080 Fairmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-2-47 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md

18 (a) Funeral director Thomas A. Hensley

(b) Address 578 W. Biddle St.

19 (a) 2 1947 (Date rec'd by registrar) Huntington Williams Jr.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 29 19 47 at 9 A. M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardio-vascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature George G. Merrill M.D. Medical Examiner.

Date signed 9/29/47

X

VS 181

Correct age is expressly important. Physicians please write plainly.

G55609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 A

Registered No. G55609

write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 754 W. Mulberry St
(c) Hospital or institution:
17-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 754 W. Mulberry
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA JOHNSON MORGAN

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Daniel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/7/1880

8. AGE: Years 67 | Months 5 | Days 21 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. County, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Benj. Johnson
13. Birthplace Md.

MOTHER
14. Maiden Name Maria Johnson
15. Birthplace Md.

16 (a) Informant Daniel Morgan (Husband)
(b) Address 754 W. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/47 (month) (day) (year)
(c) Cemetery or crematory Pleasant Rest
Location Towson, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510 -12 N. Carrollton Ave

19 (a) OCT 2 1947 (Date received by registrar) (b) Washington Hilgartner, Registrar

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH 9/28/47 19 , at 11.50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/22 19 47 to 9/28 19 47, and that I last saw alive on 19 .

Immediate cause of death: Cerebral hemorrhage — Duration 5 days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address Date signed 10/1/47

55610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

180

Registered No. C55610

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 125
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 105 E. Lafayette Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John K. Eberhart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Not Known

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Neustadt Germany (Town, county, and state)

10. Usual Occupation Baker

11. Industry or business

FATHER
12. Name Michael Eberhart
13. Birthplace Germany

MOTHER
14. Maiden Name Malburg Keller
15. Birthplace Germany

16 (a) Informant Frank V. Eberhart
(b) Address R.D.2. Gettysburg Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 4 47 (month) (day) (year)

(c) Cemetery or ~~crematory~~ Evergreen
Location Gettysburg Pa.

18 (a) Funeral director Milton Bender
(b) Address Gettysburg Pa.

19 (a) 2 1947 (Date rec'd by registrar) (b) Huntington for Wilhelm

VS 151

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MEDICAL CERTIFICATION

20. DATE OF DEATH October 1 1947, at 7:30 PM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock

Due to 1st 2nd and 3rd degree burns

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 12/5
(a) Date of injury 10-1-47 at 5:20 P.M.
(b) Where did injury occur? 105 E. Lafayette Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury House fire

23. Signature [signature] M.D. Medical Examiner

Date signed 10-1-47

119

Negro Case
G55611 43 747

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83A

Registered No. G55611

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1621 Harlem Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Male | 5 Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Annie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11 - 24 - 84

8. AGE: Years 12 | Months 10 | Days 4 | If less than one day hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation Steveador -

11. Industry or business

FATHER
12. Name Sidney Smith
13. Birthplace N. C -

MOTHER
14. Maiden Name Ellen Mc Bride
15. Birthplace N. C

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Oct. 2 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 OCT 2 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 1947, at 5 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 5 1947 to Sept 28 1947 and that I last saw him alive on Sept 25 1947

Immediate cause of death Cerebral edema — Duration 3 wks.

Due to Right Subdural hematoma — 6 wks?

Due to

Other Conditions Arteriosclerosis & hypertension

(Include pregnancy within 3 months of death)

Date of operation Sept 6, 47 & Sept 18, 47

Major findings of operation: Large left subdural hematoma; Enough RT Subdural

of autopsy: RT Subdural Hematoma

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur J Long M.D.

Address Johns Hopkins Hosp Date signed 9/29/47

Dr Chester Lukomski M.D.
per: Howard J. Mullis M.D. X

55612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G55612
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution Mercy 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-17-47 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 903 W. Lexington St. Apt.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Lane / Louise Lane

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race B | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife [illegible]
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) 8-5-07

8. AGE: Years 40 | Months 1 | Days 25 | If less than one day hr. min.

9. Birthplace Balto. - Md
(Town, county, and state)

10. Usual Occupation H.W.

11. Industry or business

FATHER
12. Name Mill Booker
13. Birthplace Md

MOTHER
14. Maiden Name Nannie Barnes
15. Birthplace Md

16 (a) Informant Husband
(b) Address

17 (a) Burial (b) Date thereof Oct. 3, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St

19 (a) 2 1947 (b) [illegible] Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-20 1947 at 4:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-17 1947 to 9-30 1947. and that I last saw h[illegible] alive on 9-29 1947

Immediate cause of death Pulm. Tuberculosis — Duration 2 wks
Due to Bronchitis — 15 yr
Due to Nodosa
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Mercy Date signed 9-30

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

VS 150

G55613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183A

Registered No. G55613

PLEASE WRITE PLAINLY, WITH UNFADING INK. Fill in all items. Use additional sheet if necessary. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Colonial Nursing Home
(c) Hospital or institution: Sorrento & Fred. Ave. 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 1
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 40 St. Josephs Home for Aged
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Bujanowska Bujanowski

3 (b) If veteran, name war

(c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	

6 (b) Name of husband or wife Frank Bujanowski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years	Months	Days	If less than one day
78			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Olszewski
13. Birthplace Poland

MOTHER
14. Maiden Name Ambrozewicz
15. Birthplace Poland

16 (a) Informant Colonial Home Records
(b) Address Sorrento & Frederick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 3 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary (Cem.
Location Balto. County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 (a) OCT 2 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/29/1947, at 11:58 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1/1947 to 9/29/1947 and that I last saw her alive on 9/24/1947.

Immediate cause of death: Cerebral Hemorrhage — Duration 4 wks.
Due to Hypertension
Due to Arteriosclerosis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos. Martin, Jr. M.D.
Address 1933 Balto. St. Date signed 9/30/47

55614

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83A

Registered No. G55614

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2115 N. Howard St
(c) Hospital or institution: 12-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2115 N. Howard
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nora Winston Minor

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife James
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1899

8. AGE: Years 48 | Months 2 | Days 24 | If less than one day ____hr. ____min.

9. Birthplace Ashland Va.
(Town, county, and state)

10. Usual Occupation Laundress

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name unknown
15. Birthplace

16 (a) Informant James Minor
(b) Address 2115 N. Howard St

17 (a) Burial (b) Date thereof Oct. 2/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A. A. County

18 (a) Funeral director Mrs. Rotha Elliott's Dept
(b) Address 1129 N. Caroline St

19 (a) OCT 2 1941 (b) Huntington White Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 1947, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1 1947, to Sept 20 1947, and that I last saw h— alive on Sept 27 1947;

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to	4 wks.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2329 Guilford Ave Date signed Oct 2 1947

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

55615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131 B

Registered No. G55615

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2932 Riggs Ave
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2932 Riggs Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph J. Van Newkirk

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 23-1869

8. AGE: Years	Months	Days	If less than one day
77	11	7	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Joseph Van Newkirk
13. Birthplace Holland

MOTHER
14. Maiden Name Mary Eggleston
15. Birthplace Unknown

16 (a) Informant Chas Hoffmeyer
(b) Address 2932 Riggs Ave

17 (a) Burial (b) Date thereof Oct 4 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director Chas P Powell
(b) Address 2427 Edmondson Ave

19 (a) Oct 7 47 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30th 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15th 1947 to Sept 30 1947 and that I last saw him alive on Sept 30 1947.

Immediate cause of death	Duration
Uraemia	1½ days
Due to Chr. Nephritis	8 mos
Due to Arteriosclerosis	8 mos
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature N. J. McDermott M. D.
Address 1126 Poplar Grove St Date signed 10/2/47

G55616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G55616 Registered No.

Type or write plainly, with ink. Physicians: please write the causes of death clearly and legibly. Give full name of deceased, and correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1328 myrtle ave
(c) Hospital or institution: 17

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1328 myrtle ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Florence Fletcher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	col.	Widow

6 (b) Name of husband or wife Nov. 28. 1888

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
57	10	2	hr. min.

9. Birthplace Rockingham N. C.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Royden Nichols
13. Birthplace Rockingham N. C.

MOTHER
14. Maiden Name Elizabeth Ellerbe
15. Birthplace Rockingham N. C.

16 (a) Informant Wallena Fletcher
(b) Address 1162 W. Lafayette ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 4, 1947 (month) (day) (year)
(c) Cemetery or crematory Oakley Cem.
Location Rockingham N.C.

18 (a) Funeral director Elroy D. Wilson
(b) Address 1000 Bonaparte ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30, 1947 at 1 55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 15, 1947 to Sept. 30, 1947 and that I last saw her alive on Sept. 26, 1947

Immediate cause of death: Chronic myocarditis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. L. Bartlett M. D.

Address 718 Dolphin St. Date signed 10-1-47

G55617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G55617 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4412 Ivanhoe Ave.
(c) Hospital or institution: 27-10

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4412 Ivanhoe Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary L. Garnes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace Gladstone Va.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name unknown

13. Birthplace " "

MOTHER 14. Maiden Name unknown

15. Birthplace " "

16 (a) Informant Lillian O. Thompson

(b) Address 4412 Ivanhoe ave

17 (a) Burial (b) Date thereof Oct 5, 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Gamburg Cem

Location Bruce West Va

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Bounty ave

19 (a) OCT 8 1947 (Date rec'd by registrar) (b) Awaiting for Attiga Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 1947, at 9 P M

21. I certify that I took charge of the remains described above, held an Insp. & Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D.
Medical Examiner.
Date signed 10-1-47

5618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131A

Registered No. 55618

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 905 W. Mulberry St
(c) Hospital or institution: 18

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 905 W Mulberry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Tweden Forney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Henry Daniels

6 (c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): June 1888

8. AGE: Years: 59 | Months: 4 | Days: | If less than one day: hr. min.

9. Birthplace: Marion N. C.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: William Brown
13. Birthplace: Marion, N. C.

MOTHER
14. Maiden Name: Ella Morris
15. Birthplace: Marion N. C.

16 (a) Informant: Henry Daniels
(b) Address: 603 Yarnell St Chester Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct 5, 1947 (month) (day) (year)
(c) Cemetery or crematory: Marion Cem.
Location: Marion N. C.

18 (a) Funeral director: Cleon O. Wilson
(b) Address: 1000 Baltimore ave

19 (a) [illegible] (b) [illegible]
(Signature of local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 2nd 1947, at 1:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 24 1947 to Oct 2nd 1947 and that I last saw h[illegible] alive on 10/27 1947.

Immediate cause of death	Duration
Acute myocarditis	10 days
Due to Interstitial Nephritis	2 mo
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: J. T. Gunn
Address: 542 N. Arlington Ave Date signed: 10/27/47 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G55619 | BALTIMORE CITY HEALTH DEPARTMENT | G55619

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4508 VALLEY VIEW AVE.
(c) Hospital or institution:
– – NONE – – 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) –
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4508 VALLEY VIEW AVE.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country – – –

3 (a) FULL NAME CLEMENS W. MUELLER SR.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	MARRIED

6 (b) Name of husband or wife ROSE E. MUELLER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-18-1896

8. AGE: Years	Months	Days	If less than one day
51 50	7	12	hr. min.

9. Birthplace BALTIMORE, MARYLAND
(Town, county, and state)
10. Usual Occupation FOREMAN
11. Industry or business

FATHER
12. Name JOHN MUELLER
13. Birthplace GERMANY

MOTHER
14. Maiden Name CAROLINE ?
15. Birthplace GERMANY

16 (a) Informant ROSE E. MUELLER - WIFE
(b) Address 4508 VALLEY VIEW AVE.

17 (a) BURIAL (b) Date thereof 10-4-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director LILLY & ZEILER INC.
(b) Address 403 S. WOLFE ST.

19 (a) OCT 2 1947 (b) Huntington Williams
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 30, 1947, at 11:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 18 1947 to Sept 30, 1947, and that I last saw him alive on Sept 29 1947.

Immediate cause of death	Duration
Carcinoma of Throat	6 mo.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1016 S. East Ave. Date signed 10/2/47

V S 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55620

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 928

G55620 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15th
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 144 S. London Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth A. Elmore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Edwin J. Elmore Jr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9th 1921

8. AGE: Years 26 | Months 5 | Days 22 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation House Work

11. Industry or business at home

FATHER
12. Name Frederick V. Heller
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Sarah C. Horn
15. Birthplace Baltimore Md.

16 (a) Informant Mr. Edwin J. Elmore Jr.
(b) Address 144 S. London Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/47 (month) (day) (year)
(c) Cemetery or crematory London Park Cem.
Location 1801 Frederick Rd.

18 (a) Funeral director John F. Cowan & Son
(b) Address 961-03 Hollins St

19 (a) ..... (Date rec'd by registrar) Huntington Williams (Registrar)

VS 20 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/1 1947, at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1 1947 to 10/1 1947 and that I last saw her alive on 10/1 1947

	Duration
Immediate cause of death Resp. Failure	
Due to Pneumonia	
Due to Mitral Stenosis	
Other Conditions Rheumatic Fever, Cardiac Enlargement (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ben Gold, M. D.
Address University Hosp Date signed 10-1-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55621

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 52B

G55621
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1302 W. Lexington St.
(c) Hospital or institution: Home of Our Lady Nursing Home 28.1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5356 Reisterstown Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA M. MITCHELL

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Bernard Mitchell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1874

8. AGE: Years	Months	Days	If less than one day
73	7	20	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John L. Kreiner
13. Birthplace Balto.

MOTHER
14. Maiden Name Mary Barbara
15. Birthplace Balto.

16 (a) Informant Mr. Thomas F. Kreiner
(b) Address 3819 Colborne Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 30 1947, to Sept 30 1947, and that I last saw h alive on Sept 30 1947.

Immediate cause of death	Duration
Carcinoma of Bladder	8 mo.
Due to	
Due to	
Other Conditions Retroperitoneal abscess Ureteroenteroneo Transplants Bilat.	

(Include pregnancy within 3 months of death)
Date of operation July 22 & July 31
Major findings of operation: Ca of Bladder
Also
of autopsy: Ca of Bladder

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H Hales Shipperson M. D.
Address 1348 Block St. Balto 31 Date signed 9/30/47

X

G55622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

G55622 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 358 S. Cornwall St.
(c) Hospital or institution: 26-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 358 S. Cornwall St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUISE HILTS

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Harry Hilts
6 (c) If alive, give age 1870 years

7. Birth date of deceased (mo., day, yr.) Oct. 11, (1870)

8. AGE: Years	Months	Days	If less than one day
(77) 76	11	18	..... hr. ..... min.

9. Birthplace Canada
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Peter Brown
13. Birthplace Canada

MOTHER
14. Maiden Name * May
15. Birthplace Canada

16 (a) Informant Mrs. Irene Warner
(b) Address 358 S. Cornwall St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 8 1947 (Date rec'd by registrar) Evelyn Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29, 1947, at 6:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 16, 1947 to Sept. 29, 1947 and that I last saw h er alive on Sept. 29, 1947.

Immediate cause of death	Duration
Congestive Heart Failure	6 hours
Due to Chronic Bronchial Asthma	Unknown
Emphysema	Unknown
Due to Arteriosclerosis	Unknown
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philibert Artigiani M.D.
Address 2942 E. Fayette St. Date signed 10/1/47

G55623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G55623
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Rd.
(c) Hospital or institution: 12-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 314 E. 22nd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katharine Wachsmann

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22, 1868

8. AGE: Years 79 | Months 2 | Days 9 | If less than one day ....hr. ....min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation ---------

11. Industry or business

FATHER
12. Name Gottlieb Wachsmann
13. Birthplace Germany

MOTHER
14. Maiden Name Henrietta Kamptman
15. Birthplace Germany

16 (a) Informant Mr. Biscoe Gray
(b) Address 1418 Fidelity Bldg.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/3/47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 1, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1947, to Sept 30 1947, and that I last saw her alive on Sept 30 1947.

	Duration
Immediate cause of death Cerebral thrombosis	1 day
Due to Hypertension	4 mos
Due to Arteriosclerosis	6 mos
Other Conditions Generalized Arteriosclerosis	3 mos

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas J Mark M. D.
Address 532 E 22nd St Date signed 10/1/47

G55624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183A

G55624 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3722 Mt. Pleasant Ave.
(c) Hospital or institution:
21-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3722 Mt. Pleasant Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Rehberger

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Margaret A. Nelson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1892

8. AGE: Years	Months	Days	If less than one day
55	8	8	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Charles C.
13. Birthplace Baltimore

MOTHER
14. Maiden Name Ida B. Fray
15. Birthplace Baltimore

16 (a) Informant Wife
(b) Address 3722 Mt. Pleasant Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/47 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 Broadway.

19 (a) 2 1947 (Date rec'd by registrar) (b) Lucy Taylor Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 1947, at 7:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1947 to present 19 , and that I last saw him alive on Sept 30 1947.

Immediate cause of death Cerebral hemorrhage — Duration

Due to Malignant hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury None

23. Signature Charles G. MacMunn M. D.
Address 2911 E. Balt St Date signed Oct 1 1947

X

Please write the causes of death clearly and legibly. Physicians: please write. Information is especially important.

G55625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947 D

G55625 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 616 Parkwyrth Avenue
(c) Hospital or institution: 9-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 76 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 616 Parkwyrth Avenue (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph McEntee (Joseph Mc Entee)

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Margaret Amoss

6 (c) If alive, give age: D years

7. Birth date of deceased (mo., day, yr.) 9/8/1867

8. AGE: Years 80 | Months 0 | Days 23 | If less than one day: ######## hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Retired (Laborer)

11. Industry or business

FATHER
12. Name Daniel McEntee
13. Birthplace Ireland

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Loretta Vorsteg (Daughter)
(b) Address 616 Parkwyrth Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Avenue Baltimore, Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue
Huntingdon Millwaukee, Md.

19 (a) 1947 (b) 2 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 October 1947, at 6:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Aug death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wm. H. Kammer D. M.D. Medical Examiner
Date signed 1 Oct. 1947

G55626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 f

G55626 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 646 W. Hoffman St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A.A.
(c) City or town Rural Severn (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abraham Tanner

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex: male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of ~~husband or~~ wife Josephine Tanner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1887

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Mecklenburg Va (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

MOTHER / FATHER

12. Name Abraham Tanner

13. Birthplace Va

14. Maiden Name Alice —

15. Birthplace Va

16 (a) Informant Josephine Tanner

(b) Address 646 Hoffman

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/ 4/ '47 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location Baltimore, Md.

18 (a) Funeral director Charles H. Alexander

(b) Address 1200 McCulloh St.

19 (a) (Date rec'd by registrar) (b) ~~Livingston~~ Williams M.D. Registrar

OCT 2 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 1 1947, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 22 1947 to Oct 1 1947, and that I last saw h.[illegible] alive on Sept 27 1947.

Immediate cause of death	Duration
Acute Hepatitis	7
Due to Malignancy of Liver	7
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Douglas Shepherd M. D.

Address 604 Fulton Ave Date signed 10/2/47

Please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Physicians:

G55627

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

G55627 Registered No.

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address.....

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-

(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....

(c) City or town Habana (If outside city or town limits, write RURAL and give town)

(d) Street No. Diez de Octubre 931 Vibora (If rural give location)

(e) Citizen of foreign country? yes (Yes or No)

If yes, name country Cuba

3 (a) FULL NAME Catalina M. Alejo-Soler

3 (b) If veteran, name war.....

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 11/10/42

8. AGE: Years	Months	Days	If less than one day
4	9	22	..... hr. ..... min.

9. Birthplace Cuba (Town, county, and state)

10. Usual Occupation.....

11. Industry or business.....

FATHER

12. Name Raul Rodriguez

13. Birthplace Cuba

MOTHER

14. Maiden Name Angela Alejo-Soler

15. Birthplace Cuba

16 (a) Informant.....

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct 2-1946 (month) (day) (year)

(c) Cemetery or crematory.....

Location HAVANA CUBA

18 (a) Funeral director Graull Della Vega

(b) Address 52 N. MORLEY ST

19 (a)..... (b) Huntington Williams (Date filed by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1946, at 7 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/23 1946, to 10/2 1946, and that I last saw h alive on 10/2 1946.

Immediate cause of death Cardiac failure — Duration 12 hrs

Due to Anastomotic ulcer between Duodenum & Pulmonary artery — 20 hrs

Due to Congenital heart disease 2 pulmonic stenosis — Life

Other Conditions.....

(Include pregnancy within 3 months of death)

Date of operation 10-1-46

Major findings of operation: See above

of autopsy: Same

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide.....

(b) Date of occurrence..... at ..... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury.....

23. Signature Richard C. Clay

Address Johns Hopkins Hosp. Date signed 10-2-46 M. D.

X

55628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133a

B-55628 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Frederick
(c) City or town Emmitsburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Martin

3 (b) If veteran, name war
3 (c) Social Security Account No.

4 Sex: Male | 5 Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-14-13

8. AGE: Years 34 | Months — | Days — | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name David Martin
13. Birthplace Md.

MOTHER
14. Maiden Name Rhoda Eyerbrode
15. Birthplace Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Oct. 5, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. View Cemetery
Location Emmitsburg, Md.

18 (a) Funeral director S. L. Allison
(b) Address Emmitsburg, Md.

19 OCT 3 1947 Huntington Williams
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-2-47, at 6:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-23-47 to 10-2-47 and that I last saw him alive on 10-2-47

Immediate cause of death	Duration
Uremia	1 mo.
Due to Pyelonephritis, rt. Kidney; Surgical absence, left kidney	10 + yrs. 17 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. V. Hodges
Address Johns Hopkins Hosp. Date signed 10/3/47 M. D.

5629 TN. 110363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G55629 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 months
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2933 Aruneh Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Archibald McDonald

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-18-7785

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Sept. Married

6 (b) Name of ~~husband or~~ wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5th 1878

8. AGE: Years	Months	Days	If less than one day
69	5	26	2½ hr. min.

9. Birthplace Maryland (Balto) (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Laborer

FATHER
12. Name Archibald McDonald
13. Birthplace Maryland

MOTHER
14. Maiden Name Kathleen Wolfe
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records)

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 10/4/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto. Md.
Location

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 (a) Oct 8 1947 (Date rec'd by registrar) (b) [illegible] (Signature of registrar)

MEDICAL CERTIFICATION P M

20. DATE OF DEATH Sept/30th 1947, at 10.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 2nd/ 1947 to Sept 30 1947 and that I last saw him alive on Sept 30/ 1947

Immediate cause of death	Duration
Hypertensive & Arteriosclerotic C-V Disease	
Due to	
Due to	
Other Conditions Anemia, macrocytic, cause?	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert A. Farber M. D.
Address Balto. City Hosps Date signed 9-30-47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

55630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G55630 Registered No.

CWK-114161

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Hour
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 142 N. Exeter Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John August Kramer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of ~~husband or~~ wife Mary Kramer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? about 1857

8. AGE: Years	Months	Days	If less than one day
About 90			hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ? Kramer
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 10/4/47 (month) (day) (year)
(Burial, ~~cremation, or removal~~)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) Oct 3 1947 (Date rec'd by Registrar) (b) Interring for Williams Mortuary

MEDICAL CERTIFICATION P

20. DATE OF DEATH September 29 19 47, at 3:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 29 19 47, to Sept. 29 19 47, and that I last saw h. im alive on Sept. 29 19 47.

Immediate cause of death	Duration
Cerebral Accident	
Due to Arteriosclerosis	
Due to	
Other Conditions Dehydration & malnutrition	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature William A. Kuehnert M. D.
Address Balto City Hosp (Date signed) 10/3/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

55631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G55631
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland ~~Balto Co~~
(b) Street address ~~[illegible]~~
(c) Hospital or institution: 1213 LIGHT STREET SOUTH BALTO. GENERAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 Days
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1715 ELKINS LANE BALTO 30
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MARY KNIGHT

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOWED

6 (b) Name of husband or ~~wife~~ Joseph L. Knight
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 2 1880

8. AGE: Years	Months	Days	If less than one day
67	8	2	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name David F. Robertson
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Sarah Zepp
15. Birthplace Balto. Md.

16 (a) Informant Leo Robertson
(b) Address 1717 Light St

17 (a) Burial (b) Date thereof 10/6/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) [illegible] (Date received by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 2 1947 8:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-12-47 19__, to 10-2 1947, and that I last saw HER alive on 10-2 1947.

Immediate cause of death	Duration
CHRONIC CONGESTIVE HEART FAILURE	
Due to HYPETENSIVE CARDIO VASCULAR DISEASE	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: ENLARGED HEART, CONGESTIVE LUNGS

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature William B. Cooper Jr. M. D.
Address SOUTH BALTO. GEN. HOSP Date signed 10/3/47

VS 150

X

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

55632 NHB-12715

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 8013

G55632 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1014 Hewitt Way, Armistead Gardens
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1014 Hewitt Way (If rural give location) (Armistead Gardens)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara L. WEBB

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 9th 1944

8. AGE: Years	Months	Days	If less than one day
2	10	23	hr. min.

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Webb
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Janet Muirr
15. Birthplace Brooklyn N.Y.

16 (a) Informant William Webb
(b) Address 1014 Hewitt Way Armistead Gardens

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/5/47 (month) (day) (year)
(c) Cemetery or crematory Central
Location Frederick Co. Md.

18 (a) Funeral director William Cox Inc
(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2, 1947, at 6:45 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Diffuse sclerosis of brain (Schilder's disease)
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 10/3/47

5633 BCH B-84347

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G55633 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St Agnes Hosp.
(c) Hospital or institution: Balto Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Frederick
(c) City or town Frederick (If outside city or town limits, write RURAL and give town)
(d) Street No. 21 E 7th (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frankie Hoffman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24, 1947

8. AGE: ~~Years~~ | Months | Days | If less than one day
0 9 wks | 2 | 1 | hr. min.

9. Birthplace St Agnes. Hosp. Balto Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Francis Hoffman
13. Birthplace Md

MOTHER 14. Maiden Name Marjorie Vetter
15. Birthplace Md

16 (a) Informant Hospital Records
(b) Address St Agnes Hosp.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-4-47 (month) (day) (year)
(c) Cemetery or crematory
Location Frederick Md

18 (a) Funeral director Hart Eichhorn
(b) Address Frederick Md

19 (a) (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 / 2 / 1947 at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/25 1947 to 10/2 1947 and that I last saw her alive on 10/2 1947

Immediate cause of death: Cardiac failure, ~~asphyxia~~ malnutrition, Asphyxia
Due to Cleft palate
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. W. Mertz M. D.
Address Hagers Date signed 10/4/47

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Certificate must be signed by Medical Examiner

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195E

Registered No. G55634

55634

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminster, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Methodist Home
(If rural give location)
(e) Citizen of foreign country? (Was or No)
If yes, name country

3 (a) FULL NAME Miss Hettie M. SHARRER Scharer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race White

6 (a) Single, ~~married, widowed, or divorced~~

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1 Nov. 1860

8. AGE: Years 86 87 | Months 11 | Days 2 | If less than one day ____ hr. ____ min.

9. Birthplace Westminster Carroll Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Francis J. Sharrer
13. Birthplace Md.

MOTHER 14. Maiden Name Margaret Ourler
15. Birthplace Md.

16 (a) Informant Hospital records
(b) Address Md. General

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 6 1947 (month) (day) (year)
(c) Cemetery or crematory Westminster Cem.
Location Westminster Md.

18 (a) Funeral director J. Francis Reese
(b) Address Westminster, Md.

OCT 2 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 Oct. 1947, at 3:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 Oct. 1947, to 3 Oct. 1947, and that I last saw her alive on 2 Oct. 1947.

	Duration
Immediate cause of death Hypostatic pneumonia	2 days
Due to Cardiac decompensation	
Due to arterio sclerosis & chronic G.U.D.	
Other Conditions Fracture left hip	?

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, ~~suicide, or homicide~~
(b) Date of occurrence 9-1-47 at 10:30 A M
(c) Where did injury occur? Westminster Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Methodist Home While at work? No
(Specify type of place)
(e) Means of injury Fractured hip while getting out of Lounging chair

23. Signature M.T. Mc Longmire M.D.

Address Md. Gen. Hospital Date signed 3 Oct 1947

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

55635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G55635 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 821 Powers St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 821 Powers St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Harry A. Miller.

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Carrie F. Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1872

8. AGE: Years	Months	Days	If less than one day
75	6	29	hr. min.

9. Birthplace Pa.
(Town, county, and state)
10. Usual Occupation Retired Conductor
11. Industry or business Penna. R.R.

FATHER
12. Name Samuel Miller
13. Birthplace Pa.

MOTHER
14. Maiden Name Susanna Meals.
15. Birthplace Pa

16 (a) Informant Carrie F. Miller
(b) Address 821 Powers St.

17 (a) Burial (b) Date thereof Oct 4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Loraine Park.
Location

18 (a) Funeral director Clemens & Donovan
(b) Address 3615-17 Chestnut Ave

Oct 3 1947 (Date) (By) Registrar) Huntington Williams, M.D.

VS 150

correct age is especially important. Physicians: please write clearly

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2nd 1947, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1934, to Oct 2nd 1947, and that I last saw him alive on Oct 1 1947.

Immediate cause of death	Duration
Coronary Embolism	1 day
Due to Cardio-vascular renal disease.	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation None
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [illegible]
Address 846 W 36 St Date signed 10th D. 2/47

X

55636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G55636

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) If hospital or institution: West Balto Gen. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3635 Roland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph J. Blake

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-26-1853

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife Anna E. Blake

6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) May 8 1902

8. AGE: Years	Months	Days	If less than one day
45	4	22	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Handy man
11. Industry or business Methodist Home

FATHER
12. Name Stanislaus Blake
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie ?
15. Birthplace Maryland

16 (a) Informant Anna E. Blake
(b) Address 3635 Roland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 3/47 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Taylor Ave

18 (a) Funeral director Chenoweth & Donovan
(b) Address 3615-17 Chestnut Ave

19 OCT 3 1947 (Date rec'd by Registrar) Huntington Williams M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 1947, at 1:15 M

21. I certify that I took charge of the remains described above, held an Aug Ex Insp Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Helfrich M.D. Medical Examiner.
Date signed Sept 30, 1947

X

55637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 826

G55637 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1617 Northern Pkwy (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie V. (Dudrow) Bizek

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife: Joseph Bizek
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-22-01

8. AGE: Years 46 | Months 1 | Days 9 | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation HW
11. Industry or business

FATHER
12. Name Joshua Bush
13. Birthplace Balto

MOTHER
14. Maiden Name Nellie E. Dudrow
15. Birthplace Balto

16 (a) Informant Husband
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/47 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Pk.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-1 1947 at 10:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1 1947 to 10-1 1947 and that I last saw h[illegible] alive on 10-1 1947.

Immediate cause of death	Duration
(a) Cerebral Hemorrhage	3 hrs
Due to (b) Hypertension	?
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address [illegible] Date signed 10-2-47

VS 150

Please write plainly with pen. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

638

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1370

Registered No. G55638

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5220 Harford Road-14
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 23 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 46 Portship-22 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter B. Harvey

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-01-4249

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Nell S. Harvey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1883

8. AGE: Years	Months	Days	If less than one day
64	2	18	hr. min.

9. Birthplace New Brighton, Penna. (Town, county, and state)
10. Usual Occupation Purchasing agent
11. Industry or business American Radiator Co.,

FATHER
12. Name Albert G. Harvey
13. Birthplace Penna.

MOTHER
14. Maiden Name Caroline Boswell
15 Birthplace Penna.

16 (a) Informant Mrs. Nell S. Harvey
(b) Address 46 Portship--22

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 3, 1947 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.,

19 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30, 1947 19 , at 7:44 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29 1947 to Sept 30 1947 and that I last saw him alive on Sept 30 1947.

Immediate cause of death Cardiac failure. — Duration

Due to Toxemia (prolonged)

Due to Pneumonia and Infected Decubitus Ulcers

Other Conditions Diabetes (controlled) Hemiplegia

(Include pregnancy within 3 months of death)
Date of operation July 5, 1947
Major findings of operation: Enlarged prostate gland.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Thomas Brennan M. D.
Address 5217 Harford Road Date signed 10-1-47

V S 150

correct age is especially important. Physician: please write the causes of death clearly and legibly.

55639

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1107

G55639 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Dennison St
(c) Hospital or institution: Crawford Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36
(e) Length of stay in Baltimore (yrs., mos., or days) 70

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 506 Allendale St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Edward Webb

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mrs. Betsy Webb

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 17 May 1860

8. AGE: Years 87 | Months 4 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore City, Md.
(Town, county, and state)

10. Usual Occupation Sign painter

11. Industry or business

FATHER
12. Name Henry A Webb
13. Birthplace Hanover Pa

MOTHER
14. Maiden Name Elizabeth Warner
15. Birthplace Hanover, Pa.

16 (a) Informant Mrs. Betsy Webb
(b) Address 506 Allendale St Baltimore Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 4/47 (month) (day) (year)
(c) Cemetery or crematory Episcopal Cem.
Location Edgewood Md

18 (a) Funeral director John D. Mitchell Sons
(b) Address 1900 Eutaw Place

19 (a) [illegible] 1947 (Date rec'd by registrar) (b) Huntington Willis

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 Oct 1947 at 1:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 29 Aug 1947 to 3 Oct 1947 and that I last saw him alive on 2 Oct 1947

	Duration
Immediate cause of death: Cardiac failure	1½ hrs.
Due to: Bronchopneumonia	1 week
Due to:	
Other Conditions: Arteriosclerosis generalized	
(Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A Bradley Daugherty
Address Halethorpe Md Date signed 3 Oct 47

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5640 CWK-73216

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G55640 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Years
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3806 Mt. Pleasant Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Fohner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6-1871

8. AGE: Years	Months	Days	If less than one day
76	3	24	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Blacksmith

11. Industry or business

FATHER
12. Name Frank Fohner
13. Birthplace Germany

MOTHER
14. Maiden Name Sophie Koch
15. Birthplace Germany

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof Friday Oct 3 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location City

18 (a) Funeral director West & Funeral Home
(b) Address 2028 Allegheny Av

19 (a) Oct 3 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 30 1947, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 11 1942, to Sept. 30 1947, and that I last saw him alive on Sept. 30 1947.

Immediate cause of death Bronchopneumonia — Duration 1 day

Due to

Due to

Other Conditions Hypertensive Cardiovascular Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. J. Binford M. D.
Address Balt. City Hosp. Date signed 10-30-47

107

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

55641 (3 Transcripts)

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1947

Registered No. G55641

Type or print clearly in ink. Physicians: please write the causes of death clearly and legibly. Underline the cause to which death should be charged statistically. Be sure age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey St
(c) Hospital or institution: Good Samaritan Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Mos 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4312 Curtis Ave Curtis Bay. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma P. Eades.

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widow

6 (b) Name of husband or wife Wm D. Eades.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1873

8. AGE: Years	Months	Days	If less than one day
74	3	16	— hr. — min.

9. Birthplace Annapolis Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name John J. King.
13. Birthplace Unknown

MOTHER
14. Maiden Name " "
15. Birthplace " "

16 (a) Informant Charles T. Eades.
(b) Address 4312 Curtis Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 4 1947 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn

18 (a) Funeral director James L. McCully
(b) Address 130 E. Fort Ave Attending for Williamsville, Md

19 (a) Oct 6 1947 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 1, 1947; at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 19 1947, to Oct 1 1947, and that I last saw h[illegible] alive on Sept 30 1947.

Immediate cause of death Asphyxia Obstruction — Duration 4 yrs.
Heart Disease
Due to
Due to
Other Conditions Generalized Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stelio Impresicia
Address 1348 Block St. Date signed 10/8/47

Stelio Impresicia

G55642 Margarite

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G55642 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1714 Johnson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1714 Johnson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country No

3 (a) FULL NAME Emil Werner

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No. 212-09-5985

4. Sex: M. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Adaline Werner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1897

8. AGE: Years 50 | Months | Days 14 | If less than one day hr. min.

9. Birthplace Phila. Pa. (Town, county, and state)

10. Usual Occupation Sugar

11. Industry or business American Sugar Refining

FATHER
12. Name Paul Werner
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace " "

16 (a) Informant Mrs. Adeline Werner
(b) Address 1714 Johnson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 4, 1947 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Cemetery
Location Glenburnie A.A.Co.

18 (a) Funeral director James L. McCauley
(b) Address 136 E. Fort Ave.

19 (a) OCT 3 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 1, 1947 at 10 22 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1946 to Oct 1 1947 and that I last saw h[illegible] alive on Oct 1 1947.

Immediate cause of death	Duration
Uremia	1 week
Due to Hypertension	2
Due to Arteriosclerotic cardiovascular - Renal Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter Fohn M. D.
Address 142 E. Fort Ave Date signed 10/4/47

X

643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

Registered No. G55643

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5032 Queensbury Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5032 Queensbury Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julius Cohen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Rebecca
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1859

8. AGE: Years	Months	Days	If less than one day
90			hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name Morris Cohen
13. Birthplace Russia

MOTHER
14. Maiden Name Unkown
15. Birthplace Russia

16 (a) Informant Rebecca Cohen
(b) Address 5032 Queensbury Ave

17 (a) Burial (b) Date thereof Oct. 3, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cemetery
Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

1947 Oct 2 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 7.30

20. DATE OF DEATH October 3 1947 at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1 1947 to Oct 3 1947 and that I last saw h[illegible] alive on Oct 3 1947

Immediate cause of death	Duration
Cardiac Renal Vascular Disease	2 yrs
Due to Bostatic Carcinoma	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature
Address 2128 W North Ave Date signed 10/3/47

VS 150

Correct age in especially important. Physicians: please write plainly.

55644

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 117a

Registered No. G55644

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2135 Linden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman M. Meyer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Birdie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (town, county, and state)

10. Usual Occupation Merchant

11. Industry or business

FATHER
12. Name Morris
13. Birthplace Russia

MOTHER
14. Maiden Name Stelda
15. Birthplace Russia

16 (a) Informant Birdie Meyer
(b) Address 2135 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-5-47 (month) (day) (year)
(c) Cemetery or crematory B'Nai Israel
Location Southern Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2600 Eastern Place

19 (a) 2 1947 (Date received by registrar) (b) Huntington Williams Hy

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 Oct 1947, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/29 1947 to 10/2 1947 and that I last saw him alive on 10/2 1947

Immediate cause of death Pneumonia, post-operative

Due to Aspiration

Due to

Other Conditions Ruptured peptic ulcer

(Include pregnancy within 3 months of death)

Date of operation 9/29/47

Major findings of operation: Ruptured peptic ulcer

of autopsy: None

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard H. Pat

Address Sinai Hospital Date signed 10/2/47 M.D.

X

correct age is especially important. Physicians: Die se...

55645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44B

Registered No. G55645

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4701 Delaware Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4701 Dellaware Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clifton R. Collins Jr.

3 (b) If veteran, name war ********** | 3 (c) Social Security Account No. 220-05-8682

4. Sex Male | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife ********

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 15, 1919

8. AGE: Years 28 | Months 5 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (City or town, and state)

10. Usual Occupation Draftsman

11. Industry or business Construction

FATHER 12. Name Clifton R. Collins Sr

13. Birthplace Covington, Ky.

MOTHER 14. Maiden Name Lena E. Lafferty

15 Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Lena E. Collins

(b) Address 4701 Delaware Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-3-47 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville, Maryland

18 (a) Funeral director Loring Byers

(b) Address 5005 Park Heights Ave.

19 (a) OCT 2 1947 (Date rec'd by registrar) (b) Registration No. Williams, M.D.

V S 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 1, 1947, at 9 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 to Oct 1 - 1947, and that I last saw h[illegible] alive on Sept 30 1947.

Immediate cause of death	Duration
Malnutrition	1 mo
Due to Hodgkins Disease	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Elliott Mortimer Jr. M. D.

Address 2406 St Paul Date signed 10/2/47

X

55646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G55646 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 505 E. 30th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 505 E. 30th Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John O Bowen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Julia D Bowen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1861

8. AGE: Years 86 | Months 6 | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Mail Carrier

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Lillian E. Jamison
(b) Address Fraunton Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-4-1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director W H Archer
(b) Address Berson Md

1947 OCT 3 (Date rec'd by registrar) (Huntington Williams M.D. Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/2/47 19 at 7.30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D. Medical Examiner.
Date signed 10/3/47

Ind - Archer

55647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G55647 Registered No.

TN. 97809

13B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals 71
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 501 W. Cross St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Perry

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col	Sept.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 8th. 1902

8. AGE: Years	Months	Days	If less than one day
45	1	21	hr. min.

9. Birthplace N. C
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Eddie Perry
13. Birthplace N. C

MOTHER
14. Maiden Name Nancy Smith
15. Birthplace N. C

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave

17 (a) Burial (b) Date thereof 10-2-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co. Md

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery St

OCT 3 1947 Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION P M

20. DATE OF DEATH Sept /29th 19 47, at 3.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 11/ 19 45 to Sept 29 19 47 and that I last saw h im alive on Sept 29 19 47.

Immediate cause of death	Duration
Respiratory failure	6 da
Due to Tuberculosis of the lungs, far advanced	2 yr
Due to	
Other Conditions Chronic pyelo-nephritis	1 yr

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: see above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Joseph J Bowen Jr M. D.
Address Balto City Hosp Date signed 9-30-47

X

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G55648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 837

G55648 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 535 N. Gordon Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 535 N. Gordon Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary F. Beard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Late Edward B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 30, 1867

8. AGE Years	Months	Days	If less than one day
80	6	2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business Home

FATHER
12. Name Geo. H. Kraft
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Harriett E. Bauer
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Earle B. Kraft
(b) Address 5104 Litchfield Ave

17 (a) Burial (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave

18 (a) Funeral director John F. Boyle & Son
(b) Address 901-03 W. Fayette St.

19 (a) (Date received by registrar) (b) Signature and title of registrar

OCT 3 1947

VS 350

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2nd 1947, at 12 noon M

21. I certify that death occurred on the date above stated; that I attended deceased from Sep 28 1947, to Oct 2 1947, and that I last saw h[er] alive on Oct 2 1947.

Immediate cause of death Coma — Duration 4 days
Due to Hemiplegia
Due to Senility
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? —
(Specify type of place)
(e) Means of injury
23. Signature Charles J. Wells
Address 5276 Park Hts Date signed Oct 2 47

correct age is especially important. Physicians: please write clearly and legibly.

G55649

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 112

G55649 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: Univ. Hospital 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4619 Kernwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRIS CHILTON BROOKS

3 (b) If veteran, name war: none

3 (c) Social Security Account No.:

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mildred G. Brooks

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 12, 1893

8. AGE: Years: 54 | Months: 5 | Days: 20 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Salesmanager (Retired)

11. Industry or business: Standard Brands

FATHER
12. Name: Charles Brooks
13. Birthplace: -

MOTHER
14. Maiden Name: -
15. Birthplace: -

16 (a) Informant: Dr. Ross C. Brooks
(b) Address: 3817 Rexmere Rd. 18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/47 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) 1947 (b) Dated [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2 1947, at 2:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1947 to Oct 2 1947 and that I last saw him alive on Oct. 2 1947.

Immediate cause of death: asthma — Duration:

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature J. W. Hedyngsworth M. D.
Address Univ. Hosp. Date signed 10/2/47

VS 150

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G55650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13/a

G55650 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey St.
(c) Hospital or institution: Good Samaritan Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 521 N. Longwood St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLINTON WALTON MARSHALL, SR.

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Marie E. Marshall
nee Belschner 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1872

8. AGE: Years	Months	Days	If less than one day
75	0	24	hr. min.

9. Birthplace Annapolis, Md. (Town, county, and state)
10. Usual Occupation Clerical Work
11. Industry or business Retired

FATHER
12. Name Joseph M. Marshall
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mary Parks
15. Birthplace Balto., Md.

16 (a) Informant Mr. C. W. Marshall son
(b) Address 3202 Hayward Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/3/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) [illegible] (b) [illegible]
(Date rec'd by registrar) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30, 1947, at 5:20 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 25 1947 to Sept. 30 1947, and that I last saw him alive on Sept 30 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	Immediate
Due to Hypertensive Cardio Vascular disease	years
Due to	
Other Conditions Senility.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles Lemmon M.D. M. D.
Address 910 W. Lombard Date signed 3 Oct. 19-47.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55651

BALTIMORE CITY HEALTH DEPARTMENT ✓ G55651 Registered No.

CERTIFICATE OF DEATH 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1328 Aisquith St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1328 Aisquith St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Florence G. Murray

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-2941

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13, 1889

8. AGE: Years	Months	Days	If less than one day
58	8	0	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired (Clerk)
11. Industry or business Balto. Transit Co

FATHER
12. Name Patrick Murray
13. Birthplace Ireland

MOTHER
14. Maiden Name Ann Gordon
15. Birthplace Ireland

16 (a) Informant Mrs. Geo. Wortman
(b) Address 1328 Aisquith St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiederald
(b) Address 900 East Biddle St

19 (a) (Date rec'd by registrar) (b) Signature of registrar Williams, M.D.

OCT 2 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/30 1947, at 3 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/24 1947 to 9/30 1947, and that I last saw h[illegible] alive on 9/30 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension	
Due to Chr. nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph Faucher M.D.
Address 1441 N Ellwood Ave Date signed 10/1/47

vs 360

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55652
437344

BALTIMORE CITY HEALTH DEPARTMENT ✓ G55652
CERTIFICATE OF DEATH +307
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Dundalk,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2724 Old North Point Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Hoeckel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Elizabeth Hoeckel

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Nov - 25 - 1883

8. AGE: Years	Months	Days	If less than one day
63	10	7	____hr. ____min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Russell Hoeckel
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Baritz
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Oct 6, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefield
(b) Address 900 E. Biddle St

19 (a) (b)
(Date rec'd by registrar) Registrar

OCT VS 3 1947 Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct - 2 - 1947 at 5 35/60 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1- 1947 to 10-2- 1947 and that I last saw him alive on 10-2- 1947.

Immediate cause of death: GASTRIC HEMORRHAGE — Duration

Due to: CHRONIC DUODENAL ULCER

ARTERIOSCLEROTIC HEART DISEASE, AORTIC ANEURISM,

Other Conditions: ARTERIOSCLEROTIC, CALCIFIED AORTIC VALVE

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: AT OUR

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Truman D. Hopkins M. D.
Address Johns Hopkins Hosp Date signed 10-2-47

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55653

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G55653 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4107 Northern Pkwy.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4107 Northern Pkwy.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph R. Schloer

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Catherine (see Fach)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9, 1861

8. AGE: Years 86 | Months — | Days 23 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business no

FATHER
12. Name Robert Schloer
13. Birthplace Batavia

MOTHER
14. Maiden Name Elizabeth Fischer
15. Birthplace France

16 (a) Informant Elizabeth R. Schloer
(b) Address 4107 Northern Pkwy.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/6/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director M.W.E. Doppel's Sons
(b) Address 7110 Belair Rd. Fleetwood, Md.

19 (a) ... (Date rec'd by registrar) (b) Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 1947, at 5:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1947 to Oct 2 1947, and that I last saw h[illegible] alive on Oct 1 1947.

Immediate cause of death	Duration
Chronic myocardial disease	5 yrs.
Due to	
Due to	
Other Conditions Acute pulmonary edema	2 days

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 4116 Northern Parkway Date signed 10/2/47 (M. D.)

X

G55654

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G55654

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9½ mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1820 N. Bond
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NICHOLAS KATSOLIAS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Antonia
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1887

8. AGE: Years	Months	Days	If less than one day
60	7	15	..... hr. ..... min.

9. Birthplace Greece
(Town, county, and state)
10. Usual Occupation restaurant
11. Industry or business

FATHER
12. Name Kerisiaka Katsolias
13. Birthplace Greece

MOTHER
14. Maiden Name Georgia Kerisiaka
15. Birthplace Greece

16 (a) Informant Antonia Katsolias
(b) Address 1820 N. Bond St.

17 (a) Burial (b) Date thereof 10/4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Andrews Church Cem.
Location Anne Arundel County

18 (a) Funeral director The Dugan Bros.
(b) Address Lombard & Ann Sts.

19 (a) (b) Registrar
Date rec'd by reg. Oct 6 1947 Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 1947, at 11:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1947 to Oct 2 1947, and that I last saw h.i.N. alive on Oct. 2 1947.

Immediate cause of death	Duration
Coronary occlusion	
Due to Coronary sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. W. Hollingsworth M. D.
Address University Hosp. Date signed 10/3/47

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G55655

BALTIMORE CITY HEALTH DEPARTMENT ✓ G55655
Registered No.

CERTIFICATE OF DEATH 55B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway + Fairmount Ave
(c) Hospital or institution:
Church Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3700 Gibbons Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Pearl E. Stoker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Halbert M. Stoker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1898

8. AGE: Years	Months	Days	If less than one day
49	2	7	....hr. ....min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joshua Selby
13. Birthplace Maryland

MOTHER
14. Maiden Name Minervia Armington
15. Birthplace Maryland

16 (a) Informant Halbert Stoker
(b) Address 3700 Gibbons Ave.

17 (a) Burial (b) Date thereof 10/6/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto

18 (a) Funeral director Leonard J. Buck
(b) Address 5305 Harford Rd.

19 (a) (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

OCT 3 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2 1947, at 4:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/5 1947, to 10/2 1947, and that I last saw h[illegible] alive on 10/2 1947

Immediate cause of death Sarcomatosis — Duration since July 1947

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. Robert Hamer M.D.
Address Church Home & Hosp. Date signed 10/4/47

Correct ages in especially important cases, by records, if possible.

X

Dr. ~~E~~ G55656 BCH F60220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157a

✓ G55656
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 502 West 27th Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 502 West 27th Strreet
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ruth Palm

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1942

8. AGE: Years	Months	Days	If less than one day
4	11	29	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation child
11. Industry or business

FATHER
12. Name Joseph J. Palm
13. Birthplace Md.

MOTHER
14. Maiden Name Lillian Weaver
15. Birthplace Md.

16 (a) Informant Mr. Joseph J. Palm
(b) Address 502 West 27th Street

17 (a) Burial (b) Date thereof 10- -47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road,

19 (a) OCT 3 1947 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-2-47 19 , at 8 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from — 19 , to 10/2 1947
and that I last saw h[illegible] alive on — 19

Immediate cause of death Hydrocephalus — Duration Birth
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard L Ruck M.D.
Address 1761 E North Ave Date signed 10/3/47

V S 150

Copies are especially important. Typewriter, pencil or pen may be used.

G55657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G55657 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hosp. 74
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0sa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1130 Cookse St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John WICKMAN

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-03-0662

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years 58 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Longshoreman

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Barbara
(b) Address 800 Block Fort Ave

17 (a) Burial (b) Date thereof 10/4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Md. Co.

18 (a) Funeral director Charles F. Mell
(b) Address 1501 E Fort Ave

19 (a) (Date received by registrar) (b) Lexington Nat'l Bank, Md. Registrar

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 1 1947 at 12:35 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 10/4/47

G55658

BALTIMORE CITY HEALTH DEPARTMENT ✓ G55658
Registered No.

CERTIFICATE OF DEATH 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1905 Ashland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1905 Ashland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William Nicholas

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Married

6 (b) Name of husband or wife Lillian
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1894

8. AGE: Years	Months	Days	If less than one day
53			hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name William Nicholas
13. Birthplace Va

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Lillian Nicholas
(b) Address 1905 Ashland Ave

17 (a) Removal (b) Date thereof Oct 4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Craigsville Va.

18 (a) Funeral director Mac Pitt A. Elliott & Son
(b) Address 1129 N. Carolina St

19 (a) (b)
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 1947, at 130 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29 1947 to Sept 30 1947 and that I last saw h[illegible] alive on Sept 30 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 Days
Due to Hypertension and Cardiac Vascular Disease ?	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. K. Peters M. D.
Address 1222 N. Carolina Date signed

Correct age is especially important. Physicians: please write plainly.

VS 50

Huntington Williams Registrar

X 10-3-47

G55659

CM. 113831

BALTIMORE CITY HEALTH DEPARTMENT ✓ G55659 Registered No.

CERTIFICATE OF DEATH · 12 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE.
(c) Hospital or institution: Baltimore City Hospitals 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 17 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County 4
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2325 Reisterstown Road
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME William J. Cavalier

3 (b) If veteran, name war	3 (c) Social Security Account No.
***	***

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Edna L. Cavalier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20 -1876

8. AGE: Years	Months	Days	If less than one day
71	3 8	12	hr. min.

9. Birthplace MD.
(Town, county, and state)
10. Usual Occupation ?
11. Industry or business None

FATHER
12. Name (D) Robert H. Cavalier
13. Birthplace ? West Virginia

MOTHER
14. Maiden Name (D) Carrie Kammerer
15. Birthplace ? Maryland

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave

17 (a) Burial (b) Date thereof Oct. 4, 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 (a) (b)
(Date received by registrar) Registrar

OCT 3 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2 - 19 47 at 6.30 A M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 15- 19 47 to Oct. 2- 1947. and that I last saw him alive on Oct. 2- 19 47.

Immediate cause of death Arteriosclerotic Ht. Disease.	Duration
Due to	
Due to	
Other Conditions ? Parkinsons.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert R. Farber M. D.
Address Balto City Hosp Date signed 10-2-47

correct age is especially important. Typewriting, preferred.

VS 450

937

G55660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124B

G55660 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution:
Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 64 Y.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. WALBERT APTS. Charles & Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Silas Coun Little

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Katherine Coe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25, 1883

8. AGE: Years 64 | Months 6 | Days 7 | If less than one day ... hr. ... min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER 12. Name Harry Little

13. Birthplace Balto., Md

MOTHER 14. Maiden Name Belle Hanover

15. Birthplace Balto., Md

16 (a) Informant Mr. John D. Little

(b) Address 331 E. University Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/47 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cemetery, Md.
Location Pikesville,

18 (a) Funeral director H. W. Mears & Son

(b) Address 505 N. Calvert St.

19 (a) OCT 8 1947 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

correct age is especially important. Physicians: please write plainly.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 1947, at 7.03 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/28 1947, to 10/2 1947, and that I last saw him alive on Oct 2 1947.

Immediate cause of death	Duration
Cirrhosis of Liver	6 mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman R. Freeman M.D.

Address Union Memorial Hosp. Date signed Oct. 2, '47

X

G55661

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 46 B

G55661 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 905 Fillen
(c) Hospital or institution: 5

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 905 Fillen (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nathaniel Bowe

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 218-10-0441

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	M

6 (b) Name of husband or wife Virginia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 7-1914

8. AGE: Years	Months	Days	If less than one day
33	1	26	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name Oscar Bowe
13. Birthplace Md

MOTHER 14. Maiden Name Harriett Robinson
15. Birthplace N. C.

16 (a) Informant Virginia Bowe
(b) Address 905 Fillen St

17 (a) B (Burial, cremation, or removal) (b) Date thereof 10-5-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Wesley
Location Worcester Co. Md.

18 (a) Funeral director James F. Stewart
(b) Address Salisbury Md

19 (a) [illegible] Date rec'd by registrar 10-4-47 Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3 1947 at 7:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-19 1947 to 9-29 1947 and that I last saw h[illegible] alive on 9-29 1947

Immediate cause of death	Duration
Congestive Ht. Failure	10 da
Due to Metastatic Carcinoma liver	1 mo
Due to Gastric Carcinoma	3 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. W. McDaniel M. D.
Address 707 N. Caroline St Date signed 10-3-47

X

5662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 655662

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Wash. Co.
(c) City or town Ft. James
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Welsh

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-14-47

8. AGE: Years | Months: 1 | Days: 10 | If less than one day: 5th week hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name James Welsh
13. Birthplace ?

MOTHER — 14. Maiden Name ?
15. Birthplace

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo SEP 25 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 4 1947 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24 1947, at 9 20/24 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1947 to Sept 24 1947, and that I last saw him alive on Sept 24 1947.

Immediate cause of death: Heart Failure — Duration: One day
Due to: Post operative - excision
Due to: of lymphangioma of axilla and floor of mouth -
Other Conditions: — Space for parts
(Include pregnancy within 3 months of death)

Date of operation 9 Sept 47
Major findings of operation: - Excision - portio - lymphangioma of neck and floor of mouth -
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip Brunn
Address John Hopkins Hosp Date signed 9-24-47

X

correct age is especially important. Physicians: please write

55663 BC# B-89745

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1159

G55663 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits write RURAL and give town)
(d) Street No. 2717 Ashland ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Earles

3 (b) If veteran, name war — (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife /

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-18-47

8. AGE: Years — | Months — | Days 1 | If less than one day ——hr. ——min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joyce Earles
13. Birthplace ?

MOTHER 14. Maiden Name ?
15. Birthplace ?

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Local Johns Hopkins Medical Schoo SEP 22 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 4 1947 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-19-47 6.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-18-47 19 to 9-19-47. and that I last saw alive on 9-19-1947.

Immediate cause of death CARDIO-VASCULAR COLLAPSE — Duration
Due to ASPHYXIA NEONATORUM
Due to PREMATURITY
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. A. Spencer M.D.
Address Johns Hopkins Hosp. Date signed 9-19-47
Harriet Lane Home X

Correct age is especially important. Physicians: please write in words and figures.

55664 BC# B89589

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

Registered No. C-55664

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hosp. 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 9 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1505 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? [redacted] (Yes or No)
If yes, name country

3 (a) FULL NAME Baby of Dungeath Dancy/Dancy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: N

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/9/47

8. AGE: Years | Months | Days | If less than one day: 9 hr. — min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Jas. Milton Dancy
13. Birthplace Durham, N.C.

MOTHER
14. Maiden Name Dungeath Martha Conn
15. Birthplace Balto, Md.

16 (a) Informant Dungeath Dancy
(b) Address 1505 Edmondson Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (Date rec'd by registrar) 1947 Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9 1947 at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 9 1947 to Sept. 9 1947 and that I last saw him alive on Sept. 9 1947.

Immediate cause of death Atelectasis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John E. S. Campen M. D.
Address 639 N. Carey Date signed 9-22-47

X

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

VS 150

55665 BC# B89473

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH X 161a

G55665
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Sq Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d.
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town — Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 922 1st st Brooklyn, Md.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** BABY BOY SANFORD.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/16/47

8. AGE: Years	Months	Days	If less than one day
		2	hr. — min.

9. Birthplace BALTO MD
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name NATHEREE SANFORD
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name RHETTA SAMPLES
15. Birthplace Naylen, N. Va

16 (a) Informant —
(b) Address —

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 22 1947

18 (a) Funeral director Commissioner of Health
(b) Address

1947 SEP 4 (Date rec'd by Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/19 1947, at 4:43 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/16 19 47 to 9/19 19 47, and that I last saw him alive on 9/19 19 47.

Immediate cause of death: A Tetralogia Congenital

Due to

Due to

Other Conditions: cerebral oedema
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: as above.

Duration: 9/16 2d

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(c) Means of injury

23. Signature [illegible]
Address Franklin Sq Hosp Signed 9/22/47

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

5666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G55666 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Middle River
(If outside city or town limits, write RURAL and give town)
(d) Street No. 123 Wibedral Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Pownall

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-25-47

8. AGE: Years	Months	Days	If less than one day
			10 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER
12. Name Thomas F. Pownall, Jr.
13. Birthplace Romney, W. Va.

MOTHER
14. Maiden Name Mary Hankin
15. Birthplace Spring Gap, W. Va.

16 (a) Informant Mary Pownall
(b) Address 123 Wibedral Drive

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School SEP 30, 1947

18 (a) Funeral director Commissioner of Health
(b) Address

1947 4 1947 Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-26 1947, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/25/47 19 to 9/26/47 19, and that I last saw h[illegible] alive on 9/26/47 19

Immediate cause of death	Duration
resp insufficiency	
failure	
Due to Prematurity —	
Due to anoxia —	
Other Conditions Mother — premature separation of placenta	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: partial atelectasis —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes; fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature [illegible] M. D.
Address W 86 St. Date signed 9/28/47

correct age is especially important. Physicians: please write plainly. Do not abbreviate.

VS 150

X

G55667 BALTIMORE CITY HEALTH DEPARTMENT G55667
CERTIFICATE OF DEATH 61 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 149 W. Lafayette Ave.
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) m.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 149 W. Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Hollingsworth Camp Perkins

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Carole C.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 18, 1867
8. AGE: Years 80 | Months 4 | Days 14 | If less than one day hr. min.
9. Birthplace Kent County (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own home

FATHER
12. Name Bradford T. Camp
13. Birthplace Kent County

MOTHER
14. Maiden Name Elliot
15. Birthplace Wilmington, Del

16 (a) Informant Mrs. Boyd M. Martin
(b) Address 149 W. Lafayette Ave.

17 (a) Burial (b) Date thereof Oct. 5,47 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory CHESTEY Cemetery
Location Chestertown, Md.

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) (Date rec'd by registrar) (b) Huntington-Williams, Inc.

4 1947
VS 150

Correct age is especially important. Typewrite or print plainly in ink.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2 1947, at 7:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1934 to 2 Oct 1947, and that I last saw Dr alive on 2 Oct 1947.

Immediate cause of death: Arteriosclerotic Cardio Vascular Renal Disease — Duration: years
Due to
Due to
Other Conditions Diabetes Mellitus — 15 years
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Laymon L. Kerr M.D.
Address 1938 Linden Ave Date signed 3 Oct 47

131a

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G55668 (Registered No.)

G55668 / 183

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1230 W. Lanvale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John B. C. Wicks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 25, 1900

8. AGE: Years: 47 | Months: 3 | Days: 5 | If less than one day: hr. min.

9. Birthplace Queen Anne Co. Md. (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER
12. Name Robert Wicks
13. Birthplace Md.

MOTHER
14. Maiden Name Alice M. Green
15. Birthplace Md.

16 (a) Informant George Wicks
(b) Address 1230 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-4-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Md.

18 (a) Funeral director Wm A. Jackson
(b) Address 916 Pennsylvania Ave.

19 (a) OCT 4 1947 (Date rec'd by registrar) (b) Washington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 1947 at 5:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Sept 7/47 at 3400 ? E. Monument St
(b) Where did injury occur? Patapsco River
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Found drowned

23. Signature George G. Merrill M.D. Medical Examiner.
Date signed 10-1-47

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G55669

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G55669 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2406 Loch Raven Road
(c) Hospital or institution:

9-8

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2406 Loch Raven Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa Dixon Shaw

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife William F. Shaw
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17, 1859

8. AGE: Years	Months	Days	If less than one day
87	11	14	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Charles Dixon
13. Birthplace Maryland

MOTHER
14. Maiden Name Don't know
15. Birthplace Don't know

16 (a) Informant Mrs. Wm. Paca, Sr.
(b) Address 2406 Loch Raven Road.

17 (a) Burial (b) Date thereof 10/4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.

19 (a) (Date received by registrar) Huntington Williams, M.D. Registrar

OCT 4 1947

V S 150

Correct age is especially important. Typewriter, pencil or pen.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 1, 1947, at 2:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 8 1947 to Oct. 1 1947 and that I last saw h[illegible] alive on Oct-1 1947

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to Arteriosclerosis	
Hypertension	20 yrs
Due to Diabetes	20 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Carl H. Berman, M.D.
Address 5111 York Rd Date signed 10/3/47 M. D.

X

AB-114182 G55670

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G55670 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 6yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Middle River, Baltimore Co.,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5 Louella Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lester Cain

3 (b) If veteran, name war

3 (c) Social Security Account No. 235-12-9524

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Emma

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10- 1894

8. AGE: Years	Months	Days	If less than one day
53	5	21	hr. min.

9. Birthplace West Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Benson Cain (D
13. Birthplace West Virginia

MOTHER
14. Maiden Name Letita Moon
15. Birthplace Virginia

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 4-1947
(month) (day) (year)
(c) Cemetery or crematory Ebenezer Cem
Location Ebenezer Rd

18 (a) Funeral director John G Connelly
(b) Address 411 Eastern Ave

4 1947 (a) (b) Thurlington Williams, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION PM

20. DATE OF DEATH October 1- 1947, at 8.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-30 1947 to 10-1- 1947 and that I last saw h im alive on 10-1- 1947

Immediate cause of death Cerebral Vascular Accident — Duration

Due to Hypertension Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Vinton Jr. M. D.
Address Balto City Hosp Date signed 10-3-1947

correct age is especially important. Physicians: please write

VS 150

X

G55671

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1947

G55671 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 N. Howard
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 N. Howard (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ruth Frances Price

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Divorced

6 (b) Name of husband or wife John Whitaker
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec. 13- 1898

8. AGE: Years	Months	Days	If less than one day
49	9	19	hr. min.

9. Birthplace Howard Co. Md. (Town, county, and state)
10. Usual Occupation Secy
11. Industry or business Furniture Movrs

FATHER
12. Name Wm Price
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Rush
15. Birthplace Va

16 (a) Informant Wm Price PRICE
(b) Address 2101 N. Howard

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 10-5-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location G. A. Co. Md.

18 (a) Funeral director Samuel W. Sullivan Jr
(b) Address 1011 N. Arlington Ave

19 (a) [illegible] (Date rec'd by registrar) (b) Huntington Woodlawn Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1947, at 12.02 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/11 1947, to 10/2 1947 and that I last saw h er alive on 10/2 1947

Immediate cause of death	Duration
Coronary Occlus.	6 hrs
Due to arterio Sclerosis	yrs
Due to	
Other Conditions Arterio Sclero. Heart	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible]
Address 2040 E. Clark Date signed 10/7/47

V S 150

655672 655672 64369

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33B

Registered No. 655672

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Providence Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1832 Pennsylvania Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Anthony Hackett

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 - 4 - 1946

8. AGE: Years	Months	Days	If less than one day
	9 10	29	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business -

FATHER
12. Name Reems R. Hackett
13. Birthplace Montgomery Co. Md.

MOTHER
14. Maiden Name Maria Blair
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Reems R. Hackett
(b) Address 1832 Pennsylvania Ave.

17 (a) Burial (b) Date thereof Oct. 6, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Mrs. Geo. H. Holland
(b) Address 1691 Pennsylvania Ave

19 (a) 1947 (b)
(Date received by registrar) Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH October 3, 1947, at 10:55 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Meningitis (influenzal)

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George A. Morrill M.D.
Medical Examiner.
Date signed 10/3/47

G55673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G55673 Registered No. 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2602 Allendale Road
(c) Hospital or institution:
at Home 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 44 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2602 Allendale Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES WINGFIELD SMITHER

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Blanche C. Smither
6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) July-4-1870

8. AGE: Years	Months	Days	If less than one day
77	2	27	hr. min.

9. Birthplace Hampton, Virginia
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Retired

FATHER
12. Name William G. Smither
13. Birthplace Virginia

MOTHER
14. Maiden Name Harriet Wilson
15. Birthplace Virginia

16 (a) Informant Mrs. E.S.Hunley (daughter)
(b) Address 607 Somerset Road, City

17 (a) Burial (b) Date thereof Oct/4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108 W. North Avenue, City.

19 (a) (b) [illegible] & address
(Date rec'd by registrar)

VS 150

Correct age is especially important. Physicians, please

MEDICAL CERTIFICATION A.

20. DATE OF DEATH Oct. 2, 1947, at 2:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/29/47 19__, to 10/2/ 1947, and that I last saw him alive on Oct. 2, 1947.

Immediate cause of death	Duration
Coronary occlusion	2 days
Due to Advanced arterio-sclerosis & hypertension-?	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 2220 Garrison Blvd Date signed 10/3/47

X

G55674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G55674 Registered No. 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 506 S. Gilmore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 506 S Gilmore St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph. BALLONINSZ (Bolohny)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Josie
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.)
8. AGE: Years: 62 | Months | Days | If less than one day: hr. min.
9. Birthplace: Poland (Town, county, and state)
10. Usual Occupation: Retire
11. Industry or business

FATHER
12. Name ?
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace Poland

16 (a) Informant Joseph Ballonnisz, Jr.
(b) Address 506 S Gilmore St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 6-47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Rockdale Md
18 (a) Funeral director Joseph Kasinskas
(b) Address 6 N Washington Ave
19 (a) (Date rec'd by registrar) (b) Huntington Wilkins Registrar

OCT 4 1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 1947, at 3:55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1942 to Oct 2 1947 and that I last saw him alive on Oct 1, 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	10 min.
Due to arteriosclerosis	
Due to hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H H Bayless M. D.
Address 1600 Wilkens Ave Date signed 10-6-47

Correct age is a question important for many reasons.

G55675

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G55675 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rutland + Monument
(c) Hospital or institution:
Sanai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3500 Great Park Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Paul Hochschild

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Fanny S. Hochschild

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Sept 7 1879

8. AGE: Years 68 | Months | Days 26 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Clerk - Retail Hamburgers

11. Industry or business 9 Sons

FATHER 12. Name Jacob Hochschild,

13. Birthplace Germany

MOTHER 14. Maiden Name Minna Schechtag

15. Birthplace Germany

16 (a) Informant Mrs. Henry Behney

(b) Address Arlington Park Apts

17 (a) Cremation (b) Date thereof 10/5/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Greenmount

Location Balto. Md.

18 (a) Funeral director David Sandheim's Son

(b) Address 1902 Eutaw Place

19 (a) 1947 (b) Huntington Williams M.D.
(Date filed by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 | 3 1947 at 3:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1 1947 to 10/2 1947 that I last saw h. alive on 10/2 1947

Immediate cause of death Pul. edema — Duration 2 hr

Due to Coronary Thrombosis — 4 days

Due to Ast Scler. Hrt. Disease

Other Conditions Pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: Myocard. sclerot.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R A Cohaberg M.D.
M. D.

Address Sanai Hosp. Date signed 10/3/47

X

G55676 — BALTIMORE CITY HEALTH DEPARTMENT — G55676 Registered No.

CERTIFICATE OF DEATH 186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 19
(e) Length of stay in Baltimore (yrs., ~~mos., or days~~) 82

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Park Ave. & Slade Ave
(If rural give location)
(e) Citizen of foreign country? ~~no~~ (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac A. Oppenheim

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: white | 6 (a) Single, (married), widowed, or divorced.

6 (b) Name of husband or wife Hannah Bergendahl
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-12-65

8. AGE: Years 82 | Months 1 | Days 20 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Aaron J. Oppenheim
13. Birthplace England

MOTHER
14. Maiden Name Bessie Cohen
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. I. A. Oppenheim
(b) Address Pk. Hghts. & Slade

17 (a) Burial (b) Date thereof 10/5/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. Hebrew
Location Balto. Md.

18 (a) Funeral director Harry Sondheim & Son
(b) Address 902 Eutaw Place

19 (a) ____ (b) ____
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION P.M.

20. DATE OF DEATH Oct. 2 1947, at 10:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 28 1947, to Oct. 2 1947, and that I last saw h IM alive on Oct. 2 1947.

Immediate cause of death	Duration
Pulmonary Edema	
Due to acute circulatory collapse	
Due to	
Other Conditions fracture of neck of left femur (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, ~~suicide, or homicide~~ Fract. Lft Femur
(b) Date of occurrence 9-14-47 at M
(c) Where did injury occur? Home - Balto. Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fell down stairs at home

23. Signature [illegible] M. D.
Address Union Mem. Hosp. Date signed 10-3-47

correct age is especially important. Physicians: please write

Huntington Williams, M.D.

Hosp. X Mathis, M.D.

G55677

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G55677

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 510 N. Luzerne Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 510 N. Luzerne Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AGNES G. McMAHON

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Peter J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1-1879

8. AGE: Years	Months	Days	If less than one day
67	11	1	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Patrick Tully
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Corrogan
15. Birthplace Ireland

16 (a) Informant Mrs. Canning
(b) Address 647 Bartlett av.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 6-47 (Month) (Day) (Year)
(c) Cemetery or crematory New Cath.
Location Old Frederick Rd.

18 (a) Funeral director Wm. A. McMann
(b) Address 4201 Greenmount av.

19 Oct 4 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 15t

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2, 1947, at 2.45 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to hop death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic hypertensive cardiovascular disease.

Due to

Other Conditions Obesity

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 10-3-47

G55678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

Registered No. G55678

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution:
Union Memorial Hospital | 7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 82 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore 18
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2917 St. Paul Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Birmingham

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Mak | 5. Color or race: Wh Mfc | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mrs. John H. Birmingham
6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) 2/13/65

8. AGE: Years 82 | Months 7 | Days 19 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name C. Meredith Birmingham
13. Birthplace Maryland

MOTHER
14. Maiden Name Alberta Hawkins
15. Birthplace Maryland

16 (a) Informant Daughter-Miss. Grace Birmingham
(b) Address 2917 St. Paul St. Baltimore 18 Md.

17 (a) Burial (b) Date thereof 10/4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory West Liberty Cem.
Location Balto. Co. Md.

18 (a) Funeral director John Burns & Sons
(b) Address Towson, Md.

19 (a) OCT 4 1947 (b)
(Date rec'd by registrar) Registrar

VS 150

correct age is especially important. Physicians: please write the causes of death clearly, using terms that convey definite information to the lay mind. Do not use abbreviations or symbols.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 1947, at 1 15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from September 25 1947, to October 2 1947, and that I last saw him alive on October 2 1947.

	Duration
Immediate cause of death Acute Pulmonary embolism	
Due to mural thrombus	
Due to	
Other Conditions Small bowel obstruction due to adhesions	

(Include pregnancy within 3 months of death)

Date of operation Sept. 27, 1947

Major findings of operation: obstruction, 3 feet from ileocecal valve

of autopsy: Pulmonary embolism

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work?
(Specify type of place)
(e) Means of injury

23. Signature James W. C. Finney M. D.
Address Union Memorial Hosp. Date signed 10-2-47

G55679

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

G55679 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1016 Druid Hill Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1016 Druid Hill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lottie C. Murray

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Levi C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 21, 1876

8. AGE: Years 71 | Months 1 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state).

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Richard Taylor
13. Birthplace Va

MOTHER
14. Maiden Name Rachel ? ? ?
15. Birthplace Va

16 (a) Informant Mr. Levi Murray
(b) Address 1016 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 4 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Lyd. H. Hoffman
(b) Address 1631 Druid Hill

19 (a) OCT 1947 (Date received by registrar) Penelope Williams (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/4/47 at 11 30 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from 4/5 1947 to 10/1 1947 and that I last saw h[illegible] alive on 10/1/47.

Immediate cause of death: Carcinoma of Uterus — Duration: 2 years
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 45 W. Biddle St. Date signed 10/14/47

VS 150

corrected age is apparently inaccurate. Please investigate.

G55680

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G55680 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 Tunbridge Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 78 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 600 Tunbridge Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA PRATT

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife John Joseph Pratt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27, 1867

8. AGE: Years	Months	Days	If less than one day
80	2	5	hr. min.

9. Birthplace Austria
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Hora
13. Birthplace Austria

MOTHER
14. Maiden Name Unknown
15 Birthplace Austria

16 (a) Informant: Mr. John J. Pratt, Jr.
(b) Address 600 Tunbridge Rd.

17 (a) Burial (b) Date thereof 10/4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Md.

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) (Date received by registrar) (b) Registrar

OCT 4 1947

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 1947, at 5.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] 19[illegible] to [illegible] 19[illegible] and that I last saw h[illegible] alive on [illegible] 19[illegible].

Immediate cause of death	Duration
Myocardiation	
Due to Cerebrovascular	two
Due to Stroke	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Fred Rumig M. D.
Address 600 Tunbridge Rd. Date signed

X

G55681

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 99

G55681 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 N. Broadway
(c) Hospital or institution: Church Home Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Not Known

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4209 Belmare Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME MRS Amelia Fehte (EMMA AMELIA FEHTE)

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife: William Fehte
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Feb. 7, 1865

8. AGE: Years	Months	Days	If less than one day
82	7	25	____ hr. ____ min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual Occupation: none
11. Industry or business: —

FATHER
12. Name: Not Known
13. Birthplace: Germany

MOTHER
14. Maiden Name: Not Known
15. Birthplace: Germany

16 (a) Informant: Mr & Mrs. Paul W. Eckels
(b) Address: 4209 Belmar Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-6-47 (month) (day) (year)
(c) Cemetery or crematory: Parkwood cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS
(b) Address: NORTH AVE. & BROADWAY

19 (a) ____ (b) ____ (Date rec'd by registrar) Registrar

OCT 50 4 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2nd 1947, at 3:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 2 1947 to Oct. 2nd 1947 and that I last saw her alive on Oct. 2nd 1947

Immediate cause of death: SHOCK

Due to: Mesenteric Thrombosis

Due to: Prolapse of Rectum

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation:

of autopsy: Mesenteric Thrombosis

Duration: NOT known according to family doctor, illness began 9/30/47

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? INC. (Specify type of place)
(e) Means of injury:

23. Signature: Lee M. HOWARD M. D.
Address: Church Home Hosp. Date signed: 10/2/47

X

G55682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 14

G55682

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Herring Run & Harford
(c) Hospital or institution:
Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9da
(e) Length of stay in Baltimore (yrs., mos., or days) 10yrs 11mos 16da

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 18 W. 21st St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Myles Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-16-36

8. AGE: Years	Months	Days	If less than one day
10	11	16	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name Myles Williams
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Braxton
15. Birthplace Virginia

16 (a) Informant mother
(b) Address 18 W. 21st St. Balt.

17 (a) Burial (b) Date thereof 10/4/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. H. Nelson
(b) Address 1303 Pennsylvania Ave

19 (a) (b) Penrington-Foss-Willis Registrar
(Date rec'd by registrar)

OCT 4 1947

S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-2-1947, at 9:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-23-1947 to 10-2-1947, and that I last saw him alive on 10-2-1947

	Duration
Immediate cause of death Cardio-respiratory failure	24hrs
Due to Tbc. meningitis	5mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John F. Bigler, Jr. M. D.
Address Sydenham Hosp. Date signed 10-3-47

X

CORRECT AGE IS ESPECIALLY IMPORTANT. Registration is permanent.

G55683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G55683 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 233 S. Augusta Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lee Foster Clarke

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-09-2357

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Geneva M.

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) April 21, 1898

8. AGE: Years	Months	Days	If less than one day
49	5	12	....hr. ....min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Salesman - Driver
11. Industry or business Forestale Brewery

FATHER
12. Name Arthur Pitts Clarke
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Margaret E. Cogle
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Geneva M. Clarke
(b) Address 233 S. Augusta Avenue

17 (a) Burial (b) Date thereof 9/6/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd. Balto Md

18 (a) Funeral director E. W. Lamereaux
(b) Address 4510 Liberty Heights Ave

19 (a) 1947 (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3 1947, at 2 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary sclerosis with thrombosis; Hemiplegia

Due to Arteriosclerosis, ulcerated, Hypertrophy and dilitation of the heart; Chronic nephritis

Other Conditions Luetic, mitral and aortic, Congestion of all viscera
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ....., at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Haskins M.D.
Medical Examiner.
Date signed 10-4-47

G55684

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 194a

G55684 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2727 Winchester St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2727 Winchester St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julius T. Teufer

3 (b) If veteran, name war
3 (c) Social Security Account No.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 3rd 1947, at 5:30 P M

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Carolyn Teufer
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) February 18, 1898

8. AGE: Years	Months	Days	If less than one day
49	7	15	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Plumbing & Heating
11. Industry or business Contract - Self

FATHER
12. Name August Teufer
13. Birthplace Germany

MOTHER
14. Maiden Name Dora Schlutter
15. Birthplace Germany

16 (a) Informant Mrs. Carolyn Teufer
(b) Address 2724 Winchester St.

17 (a) Burial (b) Date thereof Oct. 6, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore, Md.

18 (a) Funeral director Miller & Amoroso
(b) Address 4810 Liberty Heights Ave.
Huntington Williams, Mgr

19 47 (a) (b)
(Date rec'd by registrar) Registrar

21. I certify that I took charge of the remains described above, held an Eng Exam thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
~~Hemorrhage~~ Coronary Occlusion
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William S. Gilbert M.D.
Medical Examiner.
Date signed Oct 7 - 1947

VS 181

G55685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

G55685
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 Hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Aberdeen
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Warren Hamilton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband or~~ wife Dorothy Blummer

6 (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) June 15-1909

8. AGE: Years 38 | Months 3 | Days 19 | If less than one day ____ hr. ____ min.

9. Birthplace Harford Co. Md
(Town, county, and state)

10. Usual Occupation Bread deliveryman

11. Industry or business Dairy Farm

FATHER
12. Name Hays Hamilton
13. Birthplace Harford Co. Md

MOTHER
14. Maiden Name Cordelia Jarrett
15. Birthplace Harford Co. Md

16 (a) Informant Mrs. Warren Hamilton
(b) Address Aberdeen Md. R.F.D.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 5 1947 (month) (day) (year)
(c) Cemetery or crematory Bohees
Location Aberdeen Md

18 (a) Funeral director Henry Fanning Hoss
(b) Address Aberdeen, Md.

19 (a) (Date received by registrar) (Signature) Registrar

OCT 4 1947
VS 19

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4 1947, at 2:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Toxemia

Due to Extensive 1st, 2nd, and 3rd degree burns

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-3-47 at 3:30 P.M. Harford Co. Md
(b) Where did injury occur? Route # 24 1 mile north of Edgewood
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? yes
(d) Means of injury Explosion of gasoline

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 10-4-47

BC# G-86324

BALTIMORE CITY HEALTH DEPARTMENT

G55686 CERTIFICATE OF DEATH 119a

Registered No. G55686

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 6 weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1018 N. Carlton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PATRICIA ANN JONES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13, 1947

8. AGE: Years | Months 1 1/2 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Fred Jones.
13. Birthplace Washington, Georgia.

MOTHER
14. Maiden Name Ruth Griffin
15. Birthplace Williamston, N.C.

16 (a) Informant Fred Jones.
(b) Address 1018 N. Carlton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 4, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) OCT 4 1947 (Date received by registrar) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 1947, at 9 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1947 to Oct 2 1947 and that I last saw her alive on Oct 2 1947

Immediate cause of death	Duration
Respiratory failure	
Due to Convulsions, dehydration	
Due to Diarrhea	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. A. Aplenbeemer
Address University Hosp Date signed M. D. 10-2-47

X

G55687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G55687 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore Hosp 9-
(d) Length of stay in hospital or inst. (yrs., mos., or days) same
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Hos
(If outside city or town limits, write RURAL and give town)
(d) Street No. 624 St. Sarah Anne St.
(Give usual residence location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nathan Sweets (Nathaniel Sweets)

3 (b) If veteran, name war: I W.W.

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Isabella Sweets

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1892,

8. AGE: Years 54 | Months 10 | Days 5 | If less than one day ____hr. ____min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Daniel Sweets.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Henrietta
15. Birthplace Baltimore, Md.

16 (a) Informant Isabella Sweets.
(b) Address 624 Sarah Anne St.

17 (a) Burial (b) Date thereof Oct. 6, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N. Schroeder St

19 (a) 1947 (b) Huntington Williams Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/30 1947, at 10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the ~~causes~~ of death were

IMMEDIATE CAUSE OF DEATH
Fractured skull
Intracranial hemorrhage
Fractured ribs; Lacerated lungs
Due to Laceration of scalp and leg.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-30-47 15/9 9:30 A.M.
(b) Where did injury occur? 3106 Chelsea Ter.
(c) Did injury occur at home, on farm, industrial place, in public place? industrial While at work? yes
(d) Means of injury Fell off roof

23. Signature Howard J. Mahoney M.D.
Medical Examiner.
Date signed 9-30-47

VS 191

G55688

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 185

G55688 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 915 Washington Blvd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 915 Washington Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence E. Milke

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife ✓
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 28th 1914

8. AGE: Years	Months	Days	If less than one day
32	10	5	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation House Work
11. Industry or business at home

FATHER
12. Name John P. Milke
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Rosa A. Young
15. Birthplace Baltimore, Md

16 (a) Informant Mr John P. Milke
(b) Address 915 Washington Blvd

17 (a) Burial (b) Date thereof 10 6 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Mem. Pk
Location Washington Blvd Dorsey Rd

18 (a) Funeral director John J. Gowan & Son
(b) Address 901-07 Hollins St.

19 1947 Date rec'd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 3rd 1947, at 3:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from October 2 1947 to October 3 1947 and that I last saw her alive on Oct 3 1947

Immediate cause of death	Duration
a circulatory collapse	6 Hours
Due to status epilepticus	12 Hours
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathan Roenau M. D.
Address 206 S. Gilmor St. Date signed 10-3-47

V S 150

G55689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47a

G55689 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts. D. of A.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL, and give town)
(d) Street No. 707 W. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William F. Stewart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4th 1884

8. AGE: Years	Months	Days	If less than one day
63	5	29	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Marble Letter
11. Industry or business Post Office

FATHER
12. Name Francis A. Stewart
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Emma A. Burns
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Wm Carroll Pierpoint
(b) Address 2703 Winchester Ave

17 (a) Burial (b) Date thereof 10/6/47 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location 3801 Frederick Rd.

18 (a) Funeral director John F. Govan & Son
(b) Address 901-03 Baltimore St

19 (a) 4 1947 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/3 1947, at 1 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Carcinoma of Larynx

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Pulaski M.D.
Medical Examiner.
Date signed 10/3/47

G55690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G55690 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 644 N. Carey St
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 644 N. Carey St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph F. Straiten
3 (b) If veteran, name war: No
3 (c) Social Security Account No.
4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Frances Straiten
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 1, 1883
8. AGE: Years 64 Months 7 Days 2 If less than one day hr. min.
9. Birthplace Calvert County, Maryland (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business Farm

FATHER
12. Name Henry Straiten
13. Birthplace Calvert County, Maryland

MOTHER
14. Maiden Name ?
15. Birthplace Calvert County, Md.

16 (a) Informant Walter Straiten
(b) Address 2 26 N. Stricker St., Balto.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 6 47 (month) (day) (year)
(c) Cemetery or crematory Brooks Chapel
Location Calvert Co Md
18 (a) Funeral director P. L. Tennell
(b) Address Prince Frederick Md
19 (a) 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3 1947 at 8:10 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 9-24 1947 to 10-3- 1947 and that I last saw him alive on 10-3- 1947
Immediate cause of death Carcinoma of Stomach — Duration 10 mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 9-26-47
Major findings of operation Carcinoma of Stomach
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature John E. D. Campler M. D.
Address 636 N. Carey St Date signed 10-3-47

VS 150

copy of age is especially important. Physicians: please write the causes of death clearly and legibly.

G55691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G55691 Registered No. 1250

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1927 W. Fayette St
(c) Hospital or institution: 0
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 N. Ashburton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN HENRY STIRN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Katherine E. Sporle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/13/62

8. AGE: Years 85 | Months 2 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Retired about 20 yrs

11. Industry or business

FATHER
12. Name Louis Stirn
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Fredericka Kummer
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Katherine Feeley
(b) Address 1927 W. Fayette Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/6/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Baltimore Md

18 (a) Funeral director H. H. Mears and Son
(b) Address 805 N. Calvert St

19 (a) 1947 (Date rec'd by registrar) Washington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/x/ 1947 at 9A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/28/ 1947 to 10/x/ 1947 and that I last saw h[illegible] alive on 10/1/ 1947.

Immediate cause of death Acute Hepatitis

Due to Malnutrition

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.
Address 1933 W. Balto St Date signed 10/3/47

Correct age is especially important. If uncertain, please write "about."

G55692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G55692 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 25-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1330 Cambria St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Andrew Valko

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July, 1913

8. AGE: Years 34 | Months 2 | Days | If less than one day hr. min.

9. Birthplace Dunbar, Pa. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name John Valko

13. Birthplace Austria

MOTHER 14. Maiden Name Anna Lukas

15. Birthplace Austria

16 (a) Informant Joseph Valko

(b) Address Dunbar, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 7 1947 (month) (day) (year)

(c) Cemetery or crematory S.S. Peter & Paul

Location Dunbar, Pa.

18 (a) Funeral director Harry H Hyde

(b) Address 4101 Edmondson Ave

19 (a) OCT 5 1947 (Date rec'd by registrar) (b) Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3 1947, at 1 00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry) Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage (Apoplexy)

Due to Hypertension

C. J. D.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Earl L. Voglis M.D. (Medical Examiner)

Date signed 10-3-47

G55693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G55693 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3034 Baker St.
(c) Hospital or institution: 16-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3034 Baker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AMELIA E. CASEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Robert P. Casey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 27, 1857

8. AGE: Years	Months	Days	If less than one day
90	1	6	hr. min.

9. Birthplace Mt. Savage, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Zacharias Webb
13. Birthplace England

MOTHER
14. Maiden Name Ann Glear
15. Birthplace England

16 (a) Informant Mrs. Ellen Rutter
(b) Address 3034 Baker St.

17 (a) Burial (b) Date thereof 10/6/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rose Hill Cem.
Location Cumberland, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 5 1941 (b)
(Date rec'd by registrar) Registrar

VS 150

correct age is especially important. Physicians, please w

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1st 1947, to Oct 3rd 1947. and that I last saw her alive on Oct 3rd 1947.

Immediate cause of death	Duration
Carcinoma of Breast c metastases to bones	3 yrs
Due to and Cerebral apoplexy	1 wk
Due to	
Other Conditions senility	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 3033 W worth St Date signed 10/3/47

X

C55694 (Reg. No. 11146)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

C55694 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave. 3-2
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 628 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Albert Lushbaugh

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband Hettie Hill Lushbaugh
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31, 1890

8. AGE: Years	Months	Days	If less than one day
57 ?	6	2 ?	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ? Boyer
15. Birthplace Virginia

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 10/6/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 1047 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3 1947 at 5.35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 28 1947 to Oct. 3 1947 and that I last saw h. im alive on Oct. 3 1947

Immediate cause of death	Duration
Left hemiplegia due to	6 days
Cerebral Thrombosis, right	6 days
Due to cerebral arteriosclerosis	2 yrs
Arteriosclerotic Heart Disease	4 yrs
Due to with cardiac hypertrophy, auricular fibrillation, and	
Other Conditions cardiac insufficiency, hydrothorax, left, Splenic infarct	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hosps Date signed 10-3-47

G55695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

G55695 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2921 Ellicott Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-07
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2921 Ellicott Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN CHRISTOPHER FREY, SR.

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Elizabeth Dorothea Frey (nee Bensel) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19, 1885

8. AGE: Years	Months	Days	If less than one day
62	5	14	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Penna. R. R.

FATHER
12. Name Louis Frey
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Elizabeth Doessinger
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Elizabeth D. Frey
(b) Address 2921 Ellicott Drive

17 (a) Burial (b) Date thereof 10.6.47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) Harrington Williams M.D. Registrar
(Date filed by registrar)

OCT 9 1947

VS 150

Correct age is essential for comparative purposes; please verify.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3, 1947, at 5:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 1947, to Oct 1 1947, and that I last saw him alive on Oct. 1 1947.

Immediate cause of death	Duration
Arteriosclerotic heart disease	about 4 years
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo J. Gover M. D.
Address 1 Mallow Hill Ave. Date signed 10/3/47

X

G55696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 36

G55696 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Rd + Herring Run
(c) Hospital or institution:
Sydenham Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 52 Seversky Ct
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Hubbard Blalock ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Lloyd U. Blalock
6 (c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) 8-24-17

8. AGE: Years	Months	Days	If less than one day
30	1	16	hr. min.

9. Birthplace Ennis-Unicoi Co. - Tennessee
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charlie Hubbard
13. Birthplace

MOTHER
14. Maiden Name Grace K. Kirkpatrick
15. Birthplace Charlotte, N.C.

16 (a) Informant Husband
(b) Address 52 Severesky Ct. Essex - Balt. Co.

17 (a) Removal (b) Date thereof 10-4-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Burgaville N. C.

18 (a) Funeral director J. Brudzinske
(b) Address 1407 Eastern Ave.

19 47 Frances Williams, M.D. Registrar
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-3- 1947, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-29-1947 to 10-3-1947, and that I last saw her alive on 10-3-1947

Immediate cause of death	Duration
Respiratory collapse.	20 mins
Due to Aspiration of vomitus	"
Due to Poliomyelitis - paralytic - bulbar	13 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John F. Bugler, Jr. M. D.
Address Sydenham Hosp. Date signed 10-4-47

CAUSE (S) especially important in Typhoid or Paratyphoid

G55697

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G55697 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2704 Oakley Ave
(c) Hospital or institution: 27-17

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2704 Oakley Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry L. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Annie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 30, 1901

8. AGE: Years 46 | Months 8 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business Merchant

FATHER
12. Name Louis Smith
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah Pompian
15. Birthplace Russia

16 (a) Informant Samuel Millstein
(b) Address 2704 Oakley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 5, 1947 (month) (day) (year)
(c) Cemetery or crematory Petach Tikvah
Location Roedale

18 (a) Funeral director Sol, Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) Oct. 5, 1947 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4 1947, at 10.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944 to 10/4 1947, and that I last saw him alive on 9/30/47 1947.

Immediate cause of death: Cerebral + Coronary sclerosis 5 yrs?
Due to: Hypertension

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature
Address 2320 Eutaw Pl Date signed 10/4/47

Correct age is especially important, as upon it depends the value of statistics.

V S 150

G55698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G55698

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1822 W. North ave
(c) Hospital or institution: 15-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1822 W North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sarah Annie Levenson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Israel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years: 70 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or Business

FATHER
12. Name Bernard Simon
13. Birthplace Russia

MOTHER
14. Maiden Name Dessie Reba
15. Birthplace Russia

16 (a) Informant Joseph Gallery
(b) Address 6907 D St NW Washington DC

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-5-47 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herzog Mem
Location

18 (a) Funeral director Jack Levin Inc
(b) Address 1500 Eutaw Place

19 (a) (Date received by registrar) (b) Registrar

OCT 6 1947

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-3-1947, at 10:9 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1 1947, to 10-3 1947, and that I last saw h[illegible] alive on 10/3 1947.

Immediate cause of death: Acute coronary injection
Due to: Arteriosclerosis
Due to:
Other Conditions: Acute Cerebral Hemorrhage
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. L. Hornstein M. D.

Address 733 Asquith St Date signed 10/4/47

G55699 BALTIMORE CITY HEALTH DEPARTMENT G55699
Registered No.

CERTIFICATE OF DEATH 1248

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 516 S Castle St. 2-3
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 516 S. Castle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Wojtulewicz Witles

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lottie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE; Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Barber
11. Industry or business

FATHER
12. Name Joseph
13. Birthplace Poland

MOTHER
14. Maiden Name Unk.
15. Birthplace Poland

16 (a) Informant Lottie Witles
(b) Address 516 S. Castle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 6/47 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore

18 (a) Funeral director Fred W. Ozazewski
(b) Address 1930 Eastern Ave.

19 (a) (Date received by registrar) (b) Washington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3 1947, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 26 1947 to Oct. 3 1947, and that I last saw him alive on Oct. 1 1947

Immediate cause of death Cirrhosis of liver — Duration 2 years
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sigmund R. Nowak M.D.
Address 408 S. Patterson Pk. Date signed 10/4/47 M. D.

(Oct 4, 1947)

OCT

V 2 150

X

G55700 G55700

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1713 Light St 24
(c) Hospital or institution: South Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 Hanbert St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Frangkowski

3 (b) If veteran, name war

3 (c) Social Security Account No. 215 09 3920

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Francis Frangkowski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 10, 1890

8. AGE: Years	Months	Days	If less than one day
56	11	23	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name John Frangkowski
13. Birthplace Poland

MOTHER 14. Maiden Name Unk
15. Birthplace Poland

16 (a) Informant wife
(b) Address 1303 Hanbert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 7/47 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem.
Location Baltimore

18 (a) Funeral director Fred W Ozazowski
(b) Address 1930 Eastern Ave

19 (a) (Date filed by registrar) (b) Registrar

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 3 1947, at 2 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 3 1947 to Oct 3 1947; and that I last saw him alive on Oct 3 1947.

Immediate cause of death: Cerebral Hemorrhage — Duration 18 Hrs.
Due to: Hypertensive Cardio-Vascular Disease
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Harold Killen M.D.
Address South Balto Gen. Date signed Oct 3, 47

655701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 469

655701 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Raynor and Dukeland
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1309 Patapsco St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Chesley R. Hall

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Margaret E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 24 1907

8. AGE: Years	Months	Days	If less than one day
40	5	10	hr. min.

9. Birthplace Georgetown, S.C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name David J. Hall
13. Birthplace N.C.

MOTHER
14. Maiden Name Margaret Lewis
15. Birthplace N.C.

16 (a) Informant Mrs. Margaret Hall
(b) Address 1309 Patapsco St.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 10-8-47 (month) (day) (year)
(c) Cemetery or crematory Bald Eagle
Location Balto.

18 (a) Funeral director Leonard J. Luck
(b) Address 5305 Harford Road

19 (a) OCT 5 1947 (Date rec'd by registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 Oct 1947 at 9:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 25 Aug 1947 to 4 Oct 1947 and that I last saw him alive on 4 Oct 1947.

Immediate cause of death Intestinal Obstruction Ileum
Due to Adhesions following abdominal operation
Due to for Carcinoma of Body of Pancreas
Other conditions

(Include pregnancy within 3 months of death)

Date of operation 23 Sept 47
Major findings of operation: Carcinoma body of pancreas
of autopsy: Same plus intestinal obstruction

Duration
5 Days
Unknown

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. W. Bell
Address West Balto. Gen. Hospital (Date signed) 9 Oct 47

VS 150

655702 2nd #88942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

655702 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline St # 8
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 607 St. Ann Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Veronica Ann Hock

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 14, 1947

8. AGE: Years	Months	Days	If less than one day
		20	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Edgar Anthony Hock

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Gladys V. Bell

15. Birthplace Baltimore Co., Md.

16 (a) Informant Gladys V. Hock

(b) Address 607 St. Ann Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-4-47 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balto.

18 (a) Funeral director [illegible]

(b) Address 305 Harford Rd

19 (a) 5 1947 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3, 1947 at 11 05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 14, 1947 to Oct 3, 1947 and that I last saw her alive on Oct 3, 1947

Immediate cause of death Respiratory failure — Duration

Due to Atelectasis

Due to Prematurity

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Not Done

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Anthony J. DiPaula M. D.

Address St. Joseph's Hosp Date signed 10/3/47

X

Correct age is especially important. Physicians: please write plainly.

VS 150

655703

Dr. Benson
1 W. Overlea Ave.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH V/186a

655703
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2816 Inglewood Ave
(c) Hospital or institution: 27-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimpre
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2816 Inglewood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Wunderlich

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2, 1863

8. AGE: Years	Months	Days	If less than one day
84	1	3	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Christian Wunderlich
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Gardner
15. Birthplace Germany

16 (a) Informant Mrs. Nellie E. West
(b) Address 2816 Inglewood Avenue

17 (a) Burial (b) Date thereof 10-6-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Matthews
Location Balto. Md.

18 (a) Funeral director Leonard J. Rück
(b) Address 5305 Harford Road, Md.

19 (a) OCT 5 1947 (b) Huntington Mitchell, M.D.
(Date received by registrar) Registrar

V S. 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-2- 1947 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29 1947 to Oct 2nd 1947 and that I last saw her alive on Oct 1st 1947

Immediate cause of death: Shock & infarmation of age — Duration: Diner
Due to: accidental fall — Oct 2nd 1947
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 27/7
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 9-29-47 at 11 A M
(c) Where did injury occur? 2816 Inglewood Ave. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury: Shock from fall to floor
23. Signature Edward H. Benson
Address 1 W. Overlea Date signed 10 M. 3 D. /47

Howard J. Mullen, M.D.

655704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92c

655704
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4509 Schenley Rd
(c) Hospital or institution: 27-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4509 Schenley Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Swem

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Walter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years: 82 | Months | Days | If less than one day: hr. min.

9. Birthplace: Baltimore
(Town, county, and state)

10. Usual Occupation: Housework

11. Industry or business

FATHER
12. Name: Joseph Moorman
13. Birthplace: Germany

MOTHER
14. Maiden Name: Elizabeth Scherdel
15. Birthplace: Germany

16 (a) Informant: E. Swem
(b) Address: 4509 Schenley Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 7-47 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge
Location:

18 (a) Funeral director: Bernard C Haile
(b) Address: 121 E West St

19 (a) OCT 5 1947 (Date received by registrar) (b) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3 1947, at 8 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from January 21, 1947 to Oct. 3 1947 and that I last saw her alive on Oct. 3 1947

	Duration
Immediate cause of death: Acute Cardiac Failure	2 hrs (?)
Due to: Chronic Endocarditis (Rheumatic)	4 years plus
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:
23. Signature: Philip F. Lerner
Address: 2201 W. North Ave Date signed: 10/6/47

X

G55705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G55705 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution:
Church Home & Hospital
(d) Length of stay in hospital or inst. (years) [redacted] days) 16
(e) Length of stay in Baltimore (years) [redacted] days) 16

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Washington
(c) City or town Hagerstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. 206 N. Locust St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Miller, Mr. Abel Avion

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mrs Emma Miller
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) 9/28/77

8. AGE: Years	Months	Days	If less than one day
70	-	6	____ hr. ____ min.

9. Birthplace Pennsylvania
(Town, county, and state)
10. Usual Occupation Coal Dealer
11. Industry or business

FATHER
12. Name Lewis Miller
13. Birthplace Denmark

MOTHER
14. Maiden Name Hanna Olsen
15. Birthplace Denmark

16 (a) Informant Mrs. Miller
(b) Address Hagerstown, Md.

17 (a) Burial (b) Date thereof Oct 7-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rose Hill
Location Hagerstown Md

18 (a) Funeral director Geo H Munson & Son
(b) Address Hagerstown Md
Phuneting for Williamsport, Md

19 (a) [redacted]
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4 1947, at 3:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/18 1947 to 10/4 1947 and that I last saw h[redacted] alive on 10/4 1947

Immediate cause of death	Duration
Generalized Peritonitis	4 days
Due to Perforation of Colon Post Operative	
Due to Operation for	
Other Conditions Carcinoma of Rectum	

(Include pregnancy within 3 months of death)

Date of operation 9-24-30 Oct 47
Major findings of operation: Carcinoma of Rectum, Peritoneal Metastasis
Date of autopsy Generalized Peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. R. Morrow M. D.
Address Church Home & Hosp. Date signed Oct 5

R Morrow

G55706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G55706 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 629 Harvey St. 24-7
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 629 Harvey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Victoria Brooks

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Wm M.
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) 1-7-1876

8. AGE: Years 71 | Months 8 | Days 27 | If less than one day ____ hr. ____ min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Charles Walters
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Chas. F. Brookes
(b) Address 413 Cambria St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/47 (month) (day) (year)
(c) Cemetery or crematory Family burial plot Van Northumberland Co., Burgess Store

18 (a) Funeral director John F. Henry Inc
(b) Address 710 Light St.

19 (a) (Date received by registrar) Huntington Williams M.D. (Registrar)

OCT 8 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4 1947 at 6 00 AM.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1947 to Oct 4 1947 and that I last saw her alive on Oct 3 1947

Immediate cause of death Uncontrolled Hemorrhage — Duration

Due to

Due to

Other conditions Cirrhosis of Liver Pulmonary Tuberculosis

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm A Schwenck M.D.
Address 1337 E. Chase St Date signed 10/4/47

X

correct age is especially important, requirement prescribed by law

G55707

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133a

G55707 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1133 Sarah Ann St
(c) Hospital or institution: 18-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1133 Sarah Ann St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Jones ✓

3 (b) If veteran, name war | 3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14 [illegible]

8. AGE: Years	Months	Days	If less than one day
64	6	19	hr. min.

9. Birthplace N.C. (town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name James Jones
13. Birthplace N.C.

MOTHER 14. Maiden Name Mary Harris
15. Birthplace N.

16 (a) Informant Virginia Strong
(b) Address 1132 Sarah Ann St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 5-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A.A. Co Md

18 (a) Funeral director Isaiah L Brown Inc
(b) Address 1080 Monument St

19 (a) [illegible] (Signature of registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/2 1947 at 4.41 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 9/16 1947 to 10/2 1947 and that I last saw h alive on 19

Immediate cause of death — Duration 7 days
Due to Intussusception
Due to Acute Bronchopneumonia 7 days.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. Lincoln Gaston M.D.
Address 918 S. Shelton Date signed 10/4/47

Please write the correct age is especially important. Physicians: please write the causes of death clearly with ink.

VS 150

55708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

Registered No. G55708

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2033 E. 31st St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2033 E. 31st St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JESSIE S. CLARKE

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widow

6 (b) Name of husband or wife J. Thomas Clarke
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24, 1861

8. AGE: Years	Months	Days	If less than one day
86	2	9	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Elijah Brown
13. Birthplace Balto.

MOTHER
14. Maiden Name Mary Catherine Barton
15. Birthplace Balto.

16 (a) Informant Mrs. Emma C. Gorrell
(b) Address 2033 E. 31st St.

17 (a) Burial (b) Date thereof 10/6/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

OCT 6 1947 (b) Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3, 1947, at 5:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 9 1947 to Oct 3 1947 and that I last saw h. alive on Oct 3 1947.

Immediate cause of death Carcinoma of Uterus — Duration 2 Mos
Due to Uremia — Duration 1 Yr
Due to — Duration
Other Conditions — Duration
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [illegible] M.D.
Address 2136 Guilford Ave Balto 18 Date signed Oct 6/47

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

5709 G55709

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1927

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2741 Fenwick Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2741 Fenwick Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM ALBERT ALEXANDER

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Adyth B. Alexander
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1879

8. AGE: Years	Months	Days	If less than one day
68	4	11	hr. min.

9. Birthplace Belair, Md. (Town, county, and state)
10. Usual Occupation Retired Merchant
11. Industry or business

FATHER
12. Name John J. M. Alexander
13. Birthplace Harford Co., Md.

MOTHER
14. Maiden Name Mary E. Dombow
15. Birthplace Harford Co., Md.

16 (a) Informant Mrs. Adyth B. Alexander
(b) Address 2741 Fenwick Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/6/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 6 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3, 1947, at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 20 1946, to Oct 3 1947, and that I last saw h. im. alive on Oct 3 1947.

Immediate cause of death	Duration
Thrombosis Blood disease	1 yrs.
Due to	
Due to	
Other Conditions Cerebral Arterio Sclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jacob Fischer M. D.
Address 1826 N. Washington Ave. Date signed 10/4/47

X

correct age is especially important. Physicians: please write

55710

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 52 B

C55710 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4914 Cordelia Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edith E. Keller

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife George H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 27, 1885

8. AGE: Years	Months	Days	If less than one day
62	8	7	hr. min.

9. Birthplace Springfield, Ohio (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Benjamin F. Seaton
13. Birthplace Illinois

MOTHER
14. Maiden Name Lucinda Everett
15. Birthplace Ill.

16 (a) Informant Miss Hazel Keller
(b) Address 61 W. 9th St. N.Y.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Woodlawn Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves.

19 (a) OCT 6 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4 1947, at 11:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-17 1947 to 10-4 1947, and that I last saw h[illegible]R alive on 10-4 1947.

Immediate cause of death	Duration
Metastatic Carcinoma	
Due to Primary Carcinoma of the Bladder	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A. Hightower M. D.
Address University Hospital Date signed 10-5-47

5711

LW 111848

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. 55711

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Mathias William Clinton Mathias

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife: Mary Ellen Fountain
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31-1878

8. AGE: Years	Months	Days	If less than one day
69	1	2	hr. min.

9. Birthplace Maryland (Westminster)
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Oliver Mathias
13. Birthplace Md. (Westminster)

MOTHER
14. Maiden Name Lydia Wampler
15. Birthplace Westminster, Md

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 10/7/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Westminster Cemetery
Location Westminster, Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves

OCT 6 1947 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3 1947, at 8.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-2 1947, to 10-3- 1947, and that I last saw h im alive on Oct. 3- 1947.

Immediate cause of death: Bronchopneumonia — Duration: 2 days
Due to:
Due to:
Other Conditions: Senile dementia, Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: an above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. C. Robertson M. D.
Address Balt. City Hosp. Date signed 10/9/47

VS 150

55712

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G55712 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address —
(c) Hospital or institution: Womens Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) ½ day
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State — Md (b) County —
(c) City or town — Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2830 Calvert St.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Ba by Girl Emory

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/4/47

8. AGE: Years — | Months — | Days — | If less than one day 13 hr. — min.

9. Birthplace Fork, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Thomas J. Emory
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Virginia Fleury
15. Birthplace Magnolia, Md.

16 (a) Informant Mr. Thomas J. Emory
(b) Address 2830 Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 6 1947 (month) (day) (year)
(c) Cemetery or crematory St. Stephens
Location Brads haw, Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves

19 OCT 6 1947 (Date rec'd by Registrar) (b) Registrar

correct age is especially important, if over one year, if under one year, hours if under one day

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/5/47 19 , at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/5/47 19 , to 10/5/47 19 , and that I last saw h.e.R alive on 10/5/47 19

Immediate cause of death PREMATURITY — Duration

Due to —

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. L. Swanson M. D.
Address Women's Hospital Date signed 10/5/47

VS 150

5713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 7 83a

Registered No. 655713

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lenadier & Madison
(c) Hospital or institution: Maryland Gen'l Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d 3h
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Rural - Glenwood
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hilda D. Birmingham

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Lolya
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16, 1890

8. AGE: Years	Months	Days	If less than one day
56 57	10	18	hr. min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Mitchell R. Bennett
13. Birthplace Md.

MOTHER
14. Maiden Name Elva Norris
15. Birthplace Md.

16 (a) Informant Ralph Burmingham
(b) Address Glenwood Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/47 (month) (day) (year)
(c) Cemetery or crematory West Liberty Cem
Location Balto Co.

18 (a) Funeral director C. Harry Weer
(b) Address Sykesville Md.

10 CT 6 1947 Huntington Williams Mort
(Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4 1947 8:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 4 1947 to Oct 4 1947 and that I last saw h CL alive on Oct 4 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward F Burkhart
Address MD Gen'l Hosp Date signed 10/7/47 M. D.

X

55714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 55714

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Hoeathorpe (If outside city or town limits, write RURAL and give town)
(d) Street No. Brady Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George T. Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of ~~husband or~~ wife: Caroline Davis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 27, 1862

8. AGE: Years 85 | Months 8 | Days 6 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Davis
13. Birthplace Va.

MOTHER
14. Maiden Name (Unknown) Jennings
15. Birthplace Va.

16 (a) Informant Maynard Davis
(b) Address 4335 Washington Blvd

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 10/6/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cedar Hill
Location a. a. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) OCT 6 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS-181

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3, 1947, at 11 P.M. 22

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CUASE OF DEATH Shock due to fracture of skull, fracture of pelvis, Due to Fracture of both tibiae and fibulae

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-3-47 at 847 P. M. 25/2
(b) Where did injury occur? 60' nw. of Baltimore Spring Rd on Wolf Blvd.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury. Ped. struck by auto

23. Signature Carl [illegible] M.D. Medical Examiner.
Date signed 10-4-47

G55715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1577

G55715
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 wk.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3700 Nortonia Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christopher Jones

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Infant

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 23. 1946

8. AGE: Years	Months	Days	If less than one day
	11	12	hr. min.

9. Birthplace New York City
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Edgar L. Jones.
13. Birthplace Mass.

MOTHER
14. Maiden Name Gertrude Studley
15. Birthplace Mass

16 (a) Informant Edgar L. Jones
(b) Address 3700 Nortonia Rd.

17 (a) Transit (b) Date thereof 10/6/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hingham
Location Mass.

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St Paul St

19 (a) OCT 6 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/5/1947, at 2:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 28 1947 to Oct 5 1947, and that I last saw him alive on 10/5/1947.

Immediate cause of death	Duration
Spastic diplegia	
Due to Congenital cerebral defect	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Irwin Cohen M.D.
Address Sinai Hosp. Date signed 10/5/47

X

5716

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G55716
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2019 Hoffman Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2019 E. Hoffman St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN HAMILTON CORREA

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Estella R. Correa
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18, 1858

8. AGE: Years	Months	Days	If less than one day
89	5	15	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Painter (Ret.)
11. Industry or business

FATHER
12. Name Wm. Correa
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Elizabeth Paterson
15 Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Carrie B. Roberts
(b) Address 2019 E. Hoffman Street

17 (a) Burial (b) Date thereof 10- 6-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) Oct 6 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3, 1947 at 4.15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 24 19 to Oct 3 1947, and that I last saw h alive on Oct 2 1947.

Immediate cause of death	Duration
Myocarditis	1 yr.
Due to	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Janet Fisher M. D.
Address 1825 N. Wash St Date signed 10/6/47

5717

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164c

G55717 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3906 Southern Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Zimmerman Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margareth C. Zimmerman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): January 22, 1878

8. AGE: Years: 69 | Months: 8 | Days: 11 | If less than one day: hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business: Standard Oil Co

FATHER
12. Name: Henry Zimmerman Sr
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Margaret Kline
15. Birthplace: Maryland

16 (a) Informant: Mrs. Margareth C. Zimmerman
(b) Address: 3906 Southern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9/7/47 (month) (day) (year)
(c) Cemetery or crematory: Parkwood Cemetery
Location: Taylor Ave

18 (a) Funeral director: Howard N. Blight Jr.
(b) Address: 4914 Belair Road

OCT 6 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION 40

20. DATE OF DEATH October 3 1947, at 10 p. M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gunshot wound of brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-3-47 at 8 PM. M.
(b) Where did injury occur? 3906 Southern Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearms (shot self)

23. Signature Earl K. Long M.D. Medical Examiner.
Date signed 10/4/47

5718 JL - 113146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 055718

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospital 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4801 Eastern Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Mouzon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1906

8. AGE: Years	Months	Days	If less than one day
41	6	16	hr. min.

9. Birthplace S. C. (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name Benjamin
13. Birthplace S. C.

MOTHER
14. Maiden Name Alma Nexsen
15. Birthplace S. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Removal (b) Date thereof Sept. 5-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory N. C.
Location Kingsley N. C.

18 (a) Funeral director John E. Connelly
(b) Address 48 Eastern Ave.

19 Sept 6 1947 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5, 1947 2.55pm M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-19- 1947, to Sept. 5 1947, and that I last saw him alive on Sept. 5 1947.

Immediate cause of death	Duration
Respiratory failure	1 wk.
Due to Tuberculosis Pulmonary far advanced	5 mo
Due to	
Other Conditions Malnutrition + Contributory	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph J. Bowen Jr. M. D.
Address Bel Air Md. Date signed 9-6-47

VS 150

5719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G55719 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5613 Crossbill Ct.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 16yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town 5613 Crossbill Court (If outside city or town limits, write RURAL and give town)
(d) Street No. Camp Holabird Balto City (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Aaron Brown

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23, 1966

8. AGE: Years	Months	Days	If less than one day
81	5	10	hr. min.

9. Birthplace Harmons, Balto., Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mr. Preston Brown
(b) Address 5613 Crossbill Ct-Holabird

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-6-47 (month) (day) (year)
(c) Cemetery or crematory Western Star Cem
Location Baltimore co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

OCT 6 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31st 1947, at 9 A M
21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1st 47 Oct 31st 1947.
and that I last saw him alive on October 31st 47.

Immediate cause of death Cerebral Apoplexy — Duration 32 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P. V. Thomas M.D.
Address 10 77 Mansfield Blvd Dundalk Md
October 31st 1947

5720

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G55720 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4635 Falls Rd.
(c) Hospital or institution:
27
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
14
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4635 Falls Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Edward Brown

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Mal | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Ida Scott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12, 1870

8. AGE: Years 76 | Months 9 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Samuel Brown
13. Birthplace Maryland

MOTHER
14. Maiden Name Rachel Moore
15. Birthplace Maryland

16 (a) Informant Mrs. Virginia B. Lee
(b) Address 4635 Falls Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 6, 1947 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem. Co.
Location Baltimore Co., Md.

18 (a) Funeral director Mrs. Lyn. H. Holland
(b) Address 1631 Druid Hill Ave.

OCT 6 1947 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4th 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 21, 1947, to Oct 4 1947, and that I last saw h[illegible] alive on Oct 1 1947.

Immediate cause of death Coronary Thrombosis

Due to age & Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature D. Grantfort M.D.
Address 352 W. Biddle Date signed 10-6-47

721

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163a

Registered No. G55721

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Redwood Sts
(c) Hospital or institution:
University Hos. 1 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Ellicott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Columbia Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Maude Wagner

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Curtis Wagner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11, 1873

8. AGE: Years	Months	Days	If less than one day
74	8	23	hr. min.

9. Birthplace Penna
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Joseph Bechler
13. Birthplace Pa

MOTHER
14. Maiden Name Susan Beufer
15. Birthplace Pa.

16 (a) Informant Curtis Wagner
(b) Address Ellicott City Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-7-47 (month) (day) (year)
(c) Cemetery or crematory Wildwood Cem
Location Williamsport Pa.

18 (a) Funeral director F.C. Weyburn
(b) Address Ellicott City Md

19 (a) Oct 6 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

V8 150 — 1A1A

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4 1947, at 4 25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 21 1947 to Oct 4 1947
and that I last saw h alive on 19

Immediate cause of death	Duration
Arsenic Poisoning	3 mos
Due to Ingestion of Fowlers Sol.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Suicide
(b) Date of occurrence June 11 1947 at M
(c) Where did injury occur? Ellicott City Howard Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? At home While at work?
(Specify type of place)
(e) Means of injury Drank Fowlers Solution

23. Signature Alpha N Herbert M.D.
Address Ellicott City Md Date signed 10-6-47

DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY

correct age is especially important. Physicians: please

55722

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 25

G55722
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Ellicott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Fells Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E Johnson (Young)

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: F
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Geo Johnson
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 25, 1910
8. AGE: Years 37 | Months 8 | Days 10 | If less than one day .....hr. .....min.
9. Birthplace Ellicott City Md
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Wm Johnson
13. Birthplace md

MOTHER
14. Maiden Name Georgie Lee
15. Birthplace Maryland

16 (a) Informant Wm Johnson
(b) Address Ellicott City Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-9-47 (month) (day) (year)
(c) Cemetery or crematory Western Star
Location Catonsville Md.

18 (a) Funeral director P.C. Deguelderham
(b) Address Ellicott City Md

19 (a) 6 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-5-47 1947 at 7:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-15 1947 to 10-5 1947 and that I last saw h.e2 alive on 10-5 1947

Immediate cause of death: Pulmonary Embolism — Duration
Due to: Pelvic Inflammatory Disease
Due to: Honococcus Infection
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A. Hightower M.D.
Address University Hospital Date signed 10-5-47

VS 150

55723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G55723 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dot
(c) Hospital or institution: Balto City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 3Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1311 Wohler Way
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Olen B. Musgrove) Olen B Musgrove

3 (b) If veteran, name war

3 (c) Social Security Account No. 230-05-2447

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Maud B. Ayers
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) June 15th.,

8. AGE:	Years	Months	Days	If less than one day
52	52	3	19	######## min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation Pumpman
11. Industry or business Bethlehem Steel Co

FATHER
12. Name John T. Musgrove
13. Birthplace Virginia

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Maud B. Musgrove (Wife)
(b) Address 1311 Wohler Way, O'Donnell Heights

17 (a) Burial (b) Date thereof 10/7/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Musgrove Cemetery
Location Bedford, Bedford Co., Virginia

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

OCT 6 1947 Huntington Williams, M.D.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/7 1947 at 3:35 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature M.D.
Medical Examiner.
Date signed 10-8-1947

5724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 055724

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5721 Ridgedale Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5721 Ridgedale Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER C. HALL

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Margaret Hall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 13, 1886

8. AGE: Years	Months	Days	If less than one day
60	11	20	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Redmond D. Hall
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Alice A. Reader
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Margaret Hall
(b) Address 5721 Ridgedale Rd.

17 (a) Burial (b) Date thereof 10/6/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Oct 6 1947 Huntington Williams M.D.
(Date received by Registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3, 1947, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 25 to Oct 3 1947.
and that I last saw him alive on Sept 5 1947

Immediate cause of death Coronary Thrombosis

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel H Cuen M. D.
Address 5611 Ridgedale Rd Date signed 10-5-47

5725

BALTIMORE CITY HEALTH DEPARTMENT 4/ G55725
Registered No.

CERTIFICATE OF DEATH 4/ 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Cayser & Cleveland.
(c) Hospital or institution:
West Baltimore Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Ohio (b) County
(c) City or town Akron
(If outside city or town limits, write RURAL and give town)
(d) Street No. 150 MALACCA St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pauline Swindell

3 (b) If veteran, name war
3 (c) Social Security Account No. None

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Wm Henry Swindell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4, 1879

8. AGE: Years 68 | Months 6 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation None
11. Industry or business —

FATHER
12. Name Brandt
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace Germany

16 (a) Informant THEODORE E. SWINDELL
(b) Address 150 MALACCA St. AKRON Ohio

17 (a) Burial (b) Date thereof Oct 6-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location Balto Md

18 (a) Funeral director Pratt C & E. M. Walters
(b) Address Pratt & Stricker Sts

OCT 6 1947 (b) Huntington Williams MD
(Date rec'd by registrar)

VS 150

Correct age is especially important if under 1 year or 100 years

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 October 1947 at 1:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3 Oct. 1947 to 4 Oct. 1947 and that I last saw h~~er~~ alive on 4 Oct 1947

Immediate cause of death	Duration
Peripheral Circ. Failure	
Due to Probable Massive Myocardial Infarction	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lester A. Hall M.D.
Address Cayser & Cleveland Date signed 10/4/47

X

5726 LW 112948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

137a

Registered No. G55726

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 617 Savage St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Smith

3 (b) If veteran, name war —

3 (c) Social Security Account No. 705-12-3250

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	widower

6 (b) Name of husband or wife Annie M. Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 8, 1875

8. AGE: Years	Months	Days	If less than one day
71	11	25	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Peter Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth ~~Cooper~~ Kafer
15. Birthplace Md.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 6/47 (month) (day) (year)
(c) Cemetery or crematory London Pk
Location Balto Md

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Eutaw St

19 (a) OCT 6 1947 (Date received by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-3 3 19 47, at 8:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-12 1947, to 10-3 1947, and that I last saw him alive on Oct. 3 1947

Immediate cause of death	Duration
Cerebral accident	3 days
Due to arteriosclerotic cardio-vascular disease	years
Due to	
Other Conditions draining sinus pubic wound	1 mo.

(Include pregnancy within 3 months of death)
Date of operation 9/4/47
Major findings of operation: enlarged prostate
of autopsy: ASCVD

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Gordon Craft M. D.
Address Baltimore City Hosp. Date signed 10/3/47

X

55727

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G55727 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 760 Flute Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1501 E. Madison St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lavenia Wongust

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife Samuel Wongust

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace Cecil Co. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Isaac L. Archer
13. Birthplace Port Deposit Md

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Sarah Smith.
(b) Address 1510 E. Madison St. Balto

17 (a) Burial (b) Date thereof Oct. 8 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cokesbury
Location Port Deposit Md. Road

18 (a) Funeral director Wm. A. Patterson & Son
(b) Address Perryville, Md.

OCT 6 1947 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 1947, at 1145 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Carcinoma of breast
generalized arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George E. Merrill M.D.
Medical Examiner.
Date signed 10-6-47

5728

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 55228

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 4203 Liberty Heights Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4203 Liberty Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: John Niederhoefer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Walburga Niederhoefer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 30 1865

8. AGE: Years	Months	Days	If less than one day
82		5	hr. min.

9. Birthplace: Germany
(Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business: Resturant Owner

MOTHER / FATHER

12. Name: Johann Niederhoefer
13. Birthplace: Germany

14. Maiden Name: Christine Kuhl
15. Birthplace: Germany

16 (a) Informant: Pauline Niederhoefer
(b) Address: 4203 Liberty Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 7 1947 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn
Location: Woodlawn Md

18 (a) Funeral director: Harry A. Ormsrod
(b) Address: 4204 Ridgewood Ave

OCT 6 1947 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 5th 1947 at 12.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 7 1945 to Oct. 5 1947 and that I last saw him alive on Oct. 5 1947.

Immediate cause of death	Duration
1) Chronic Nephritis	2 yrs.
2) Diabetes	
Due to	
Due to	
Other Conditions (2) Diabetes Mellitus Cerebral Sclerosis Heart Disease	5 yrs.

(Include pregnancy within 3 months of death)

Date of operation: None
Major findings of operation:
of autopsy: -

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Lord F. Chambers M.D.
Address: 4108 Liberty Hts Date signed 5/6/47

1318

5729

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 55529

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2812 Winchester ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY SCAGGS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Peter Thomas B

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9 1870

8. AGE: Years 77 | Months 5 | Days 26 | If less than one day hr. min.

9. Birthplace Rockland Md (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Charles W Grimes
13. Birthplace Md

MOTHER
14. Maiden Name Rovenia Oler
15. Birthplace Md

16 (a) Informant Joseph D Scaggs
(b) Address 32-6-Ridgewood-Greenbelt

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Oct. 8 1947 (month) (day) (year)
(c) Cemetery or crematory Good Shepard
Location Rockland, Md

18 (a) Funeral director Harry A Wyche
(b) Address 4101 Edmondson Ave

(a) 6 1947 (Date rec'd by registrar) (b) Lexington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5 1947, at 4:43 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1947 to Oct 5 1947, and that I last saw h.e.c. alive on Oct 5 1947.

Immediate cause of death Respiratory failure. — Duration

Due to Cerebral haemorrhage

Due to Hypertension - Essential

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Tucker M.D.
Address West Balt. Gen'l Hosp. Date signed Oct 7, 47

X

55730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1540

Registered No. 55730

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland Gen. Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4008 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Naomi L. Johnson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Dr. Wm Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23 1907

8. AGE: Years 40 | Months 03 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Home W. ft.

11. Industry or business

FATHER
12. Name Wm C. Allen
13. Birthplace Balto.

MOTHER
14. Maiden Name Flora H (Lord)
15. Birthplace Md

16 (a) Informant Dr. Wm Johnson
(b) Address 4008 Edmondson Ave

17 (a) Burial (b) Date thereof Oct. 8 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Pimlico, Md

18 (a) Funeral director Henry A Wolfe
(b) Address 4401 Edmondson Ave

19 OCT 6 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1947 at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1947 to Oct 5 1947 and that I last saw h[illegible] alive on Oct 5 1947

Immediate cause of death: Glioma — Duration: 10 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard H. Martin M.D.
Address [illegible] Md. Gen. Hosp. Date signed 10-5-47
M. D.

correct age is especially important. Physicians: please write the

VS 150)

5731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G55731 Registered No.

GM. 113723

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 24 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 310 N Caroline ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie Monford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6 - 1888

8. AGE: Years	Months	Days	If less than one day
59	3	25	hr. min.

9. Birthplace VA
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Tallsey (D)
13. Birthplace VA.

MOTHER
14. Maiden Name Marie Corbin (D)
15. Birthplace VA.

16 (a) Informant Records Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof OCT 8, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md

18 (a) Funeral director Chas. W. Wilson
(b) Address 1005 Bedford ave

OCT 6 1947 (b)
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4 - 1947, at 1030AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 10 1947, to Oct. 4 19 47, and that I last saw her alive on Oct. 4- 1947.

Immediate cause of death	Duration
Subdural Hematoma, acute	1 week
Due to Hypertensive Cardiovascular	yrs
Due to Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. D. Robinson Jr M. D.
Address Balt City Hosp Date signed 10/5/47

X

732 Bk B-81805 BALTIMORE CITY HEALTH DEPARTMENT Registered No. G55732

CERTIFICATE OF DEATH 151

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and name town)
(d) Street No. 1113 Brewer Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Leonard Carter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex: Male | 5 Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-20-47

8. AGE: Years | Months: 3 | Days: 13 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER
12. Name Charles F. Carter
13. Birthplace Md.
14. Maiden Name Clementine Johnson
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-6-47 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn.
Location Md

18 (a) Funeral director George E. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) Date received (Registrar) 10-6-1947 (b) Huntington Williams M.D. (Registrar)

Correct age is especially important if deceased was under one year or one day.

VS · 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-3 1947 at 4:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1-47 to 10-3-1947 and that I last saw deceased alive on 10-3-1947.

Immediate cause of death: Circulatory Collapse — Duration
Due to: Overwhelming infection of furunculosis
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lee Mell Bass M. D.
Address Johns Hopkins Hosp. Date signed 10-4-47

X

5733 L - 108419

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G55733

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 520 McMechen St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl Wettenton

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 27, 1923

8. AGE: Years	Months	Days	If less than one day
24	3	5	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Noble Wettenton
13. Birthplace Md.

MOTHER
14. Maiden Name Evelyn Matthews
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 10-7-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.
18 (a) Funeral director George G. Nelson
(b) Address 1303 Pennsylvania Ave

19 (a) OCT 9 1947 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2 1947, all P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 13 1947 to Oct. 2 1947, and that I last saw her alive on Oct. 2 1947.

Immediate cause of death	Duration
Bilateral, Far advanced Caseous Pulmonary Tuberculosis with Cavitation	12 mo
Due to	
Due to	
Other Conditions Tuberculous Enteritis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Done, has records

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] Davis M. D.
Address [illegible] Date signed 10-7-47

X

55734 Transcript

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

C55734
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5718 Highgate Drive
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5718 Highgate Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard N. Keyes.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 2, 1873

8. AGE: Years	Months	Days	If less than one day
74	0	2	...hr. ...min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name James Keyes
13. Birthplace Needmore, Md.

MOTHER
14. Maiden Name Alice M. Haskell
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Nellie Keyes
(b) Address 3603 Menlo Drive.

17 (a) Burial (b) Date thereof 10-6-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director Loving-Byers
(b) Address 5005 Park Heights Ave

OCT 8 1947 (b) Huntington Williams, M.D.
(Date rec'd by Registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4, 1947, at 1 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1946 to Oct 4 1947, and that I last saw him alive on Oct 2 1947.

Immediate cause of death	Duration
(a) Myocarditis	4 yrs
Due to	
(b) Senility	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles J. Wells
Address 5276 Park Heights Date signed Oct 8 47

X

55735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G55735 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3604 Malvern ave
(c) Hospital or institution: Anderson Nursing Home 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr 2mo
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3929 Keswick Road
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Virginia Dorsey

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30, 1858

8. AGE: Years	Months	Days	If less than one day
89	3	4	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business —

FATHER
12. Name James L. Dorsey
13. Birthplace Dorchester Co Md.

MOTHER
14. Maiden Name Sarah Richardson
15. Birthplace Dorchester Co md

16 (a) Informant Miss Nannie Dorsey
(b) Address 3929 Keswick Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/7/47 (month) (day) (year)
(c) Cemetery Old Trinity Church
Location Church Creek, Md.

18 (a) Funeral director John O. Mitchell & Sons Inc.
(b) Address 1900 Eutaw Place

19 OCT 6 1947 (Date received by Registrar) (b) Washington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4 1947, at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1944, to October 4 1947, and that I last saw her alive on Oct 4 1947.

Immediate cause of death	Duration
Cerebral arteriosclerosis	3 yrs
Generalized arteriosclerosis	3
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury

23. Signature Francis W. Gluck M. D.
Address 3406 St Paul St Date signed 10/4/47

5736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G55736
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5718 Harford Road.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5718 Harford Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HERBERT F. LENT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Nellie Fitzgerald
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8, 1888

8. AGE: Years	Months	Days	If less than one day
59	8	28	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frederick Lent
13. Birthplace Md.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Nellie Lent
(b) Address 5718 Harford Road, 14

17 (a) Burial (b) Date thereof 10- -47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 OCT 6 1947 (b) Huntington Williams M.D.
Date rec'd by registrar Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6, 1947, at 5.45 P M

21. I certify that I took charge of the remains described above, held an insp. & inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 10-6-47

5737

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 83a

Registered No. G55737

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3113 Keswick Road.
(c) Hospital or institution:

13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3113 Keswick Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W. Kone.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married.

6 (b) Name of husband or wife: Mary M. Kone

6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Sept 28, 1873

8. AGE: Years	Months	Days	If less than one day
74	-	6	hr. min.

9. Birthplace Maryland.
(Town, county, and state)

10. Usual Occupation Retired Conductor

11. Industry or business Penna R.R.

FATHER
12. Name John W. Kone
13. Birthplace Md.

MOTHER
14. Maiden Name Mary R. Skipper.
15. Birthplace Md.

16 (a) Informant Mary M. Kone.
(b) Address 3113 Keswick Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 6/47 (month) (day) (year)
(c) Cemetery or crematory Loraine Park.
Location

18 (a) Funeral director Brunowell & Donovan.
(b) Address 3615-17 Eastern Ave.

19 (a) 6 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-4- 1947, at 3.40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 1942 to Oct 3 1947, and that I last saw h IM alive on Oct 3 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage.	7 days
Due to Arteriosclerosis	5 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur J Davis M. D.
Address 800 N 33rd St Date signed 10-4-47

VS 150

X

5738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 937

G55738 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3360 Chestnut Ave D.O.A.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Fullerton, Harford Co.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard T. Engle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Jennie Engle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25 1876

8. AGE: Years	Months	Days	If less than one day
70	9	10	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Carpenter, Retired.
11. Industry or business

FATHER
12. Name John H. Engle
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah C. Brady
15. Birthplace Md

16 (a) Informant Lorella E. Rapp.
(b) Address 3360 Chestnut Ave.

17 (a) Burial. (b) Date thereof Oct 8, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Johns.
Location Long Green, Harford Co

18 (a) Funeral director Shipsmith & Donovan.
(b) Address 3615-17 Chestnut Ave.

19 Oct 6 1947 (b) Huntington Williams, M.D.
(Date Rec'd By Registrar) Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH 10/4 1947 at 7.35 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. D. Schneider M.D.
Medical Examiner.
Date signed 10/5/47

G55739 BALTIMORE CITY HEALTH DEPARTMENT G55739
CERTIFICATE OF DEATH 937 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave. & Madison St.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3007 Elliott St. # 24
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James A. Millar

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 18-1887

8. AGE: Years 60 | Months 6 | Days 16 | If less than one day hr. min.

9. Birthplace BALTIMORE (Town, county, or state)

10. Usual Occupation Lumber Inspector

11. Industry or business Wooden Lumber Co

FATHER
12. Name Alexander Millar
13. Birthplace Ireland.

MOTHER
14. Maiden Name Mary Gross
15. Birthplace Ireland.

16 (a) Informant Wife
(b) Address 3007 Elliott St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/7/47 (month) (day) (year)
(c) Cemetery or crematory Woodland Mem
Location Pulaski

18 (a) Funeral director Edward F. Hoffman
(b) Address 1423 Broadway

19 (a) 6 1947 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 Oct 1947 at 4:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 28 Sept 1947 to 3 Oct 1947, and that I last saw him alive on 3 Oct 1947.

Immediate cause of death: Kidney Failure — Duration: 6 days
Due to: Hypertension Cardio-vascular disease — 10 yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Allan Ayres M.D.
Address Md. Gen. Hosp. Date signed 10-7-47

correct age is especially important. Physicians: please w

VS 150

G55740

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G55740 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 613 N. Paca Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME REVERAND WILLIAM H. THOMPSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 3, 1898

8. AGE: Years 49 | Months 8 | Days 23 | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Minister

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mildred Minor Thompson

(b) Address 596 Preston St.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Oct 1947 (month) (day) (year)

(c) Cemetery or crematory Mt Curtain

Location

18 (a) Funeral director Adolphus Halstead

(b) Address 918 DRUID Hill Ave. Huntington Williams, Mt

(Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 26, 1947, at 12.30 P M

21. I certify that I took charge of the remains described above, held an insp.& inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 9-26-47

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G55741

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G55741 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 319 S. Central Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GIUSEPPE MARCHIANO

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Frances

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 15, 1889

8. AGE: Years 57 | Months 9 | Days 19 | If less than one day hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business Gas & Electric Co.

FATHER
12. Name Giuseppe Marchiano
13. Birthplace Italy

MOTHER
14. Maiden Name Bastiana Anello
15. Birthplace Italy

16 (a) Informant Mrs. Frances Marchiano
(b) Address 319 S. Central Ave

17 (a) Burial (b) Date thereof 10-7-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Holy Redeemer
Location Belair Rd-Balt. Md

18 (a) Funeral director Frank Della Vecchia
(b) Address 52 N. Morley St.

(a) OCT 6 1947 (b) Huntington Williams M.D. Registrar
(Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4 1947, at 8:55 P.M.

21. I certify that I took charge of the remains described above, held an Inspec. and Inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Artery Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.

Date signed 10/4/47

G55742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G55742 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 701 S. Robinson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 701 S. Robinson St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Zick

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife late Catherine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17 1877

8. AGE: Years	Months	Days	If less than one day
69	10	17	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER 12. Name Frederick Zick
13. Birthplace Germany

MOTHER 14. Maiden Name Mary Leighanser
15. Birthplace Germany

16 (a) Informant Margaret Shaney (Sister)
(b) Address 112 N. Montford Ave

17 (a) Burial (b) Date thereof Oct. 7/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~xxxxxxxx~~Trinity
Location Baltimore Md.

18 (a) Funeral director Frank Della Rose
(b) Address 52 N. Morley St.

19 (Date rec'd by registrar Oct 6 1947) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4, 1947, at 7:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 12, 1940 to 10/4/47 and that I last saw h.im. alive on Oct. 2, 1947

Immediate cause of death	Duration
Congestive Heart Failure	6 hours
Due to Chronic Myocarditis	Unknown
Arteriosclerosis	Unknown
Due to	
Other Conditions Bronchial Asthma	15 yrs.
Padgett's Disease - 15 yrs.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Philibert Artigiani M.D.
Address 2942 E. Fayette St. Date signed 10/6/47

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X

G55743 BALTIMORE CITY HEALTH DEPARTMENT G55743
Registered No.

CERTIFICATE OF DEATH 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 N. Linwood Ave.
(c) Hospital or institution:
15-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3041 Edgewood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE H. HOFFMANN

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-01-1017

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Katherine Hoffmann

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 7th, 1894

8. AGE: Years 52 | Months 11 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name Bernard Hoffmann
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Grobb
15. Birthplace Germany

16 (a) Informant Mrs. G.H. Hoffmann
(b) Address 3041 Edgewood Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10/7/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director Lanahan Funeral Home
(b) Address 7401 Belair Rd.

19 (a) (Date received by registrar) (b) Huntington Williams, Registrar

0 1947

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MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4th 1947, at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 5 1944 to Oct 4 1947, and that I last saw h[illegible] alive on Oct 4 1947.

	Duration
Immediate cause of death: Coronary Thrombosis (1 day)	
Due to: Generalized Arterio-Sclerosis	
Due to: Hypertension 3 yrs at least	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature B O'Kelly M.D.
Address 100 N. Linwood Ave. Date signed 10/7/47

If correct age is especially important. Physicians: please write plainly.

G55744

BALTIMORE CITY HEALTH DEPARTMENT ✓ G55744

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 624 Redwood St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 624 Redwood St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George O'Neal.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	C	married

6 (b) Name of husband or wife Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 5th 91

8. AGE: Years	Months	Days	If less than one day
56	4	29	hr. min.

9. Birthplace A. A. County Md.
(Town, county, and state)
10. Usual Occupation Janitor.
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown.
15. Birthplace

16 (a) Informant Mrs. Ida O'Neal
(b) Address 624 Redwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-6-1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Ambrose
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

OCT 6 1947
(a) (Date rec'd by registrar) (b)

Huntington Williams Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 3 1947, at 10:30 a. M.

21. I certify that death occurred on the date above stated, that I attended deceased from 10/2/1947 to 10/3/1947 and that I last saw h[illegible] alive on 10/3/1947.

Immediate cause of death — Duration

Cerebral Hemorrhage

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. J. Taylor
Address 1522 Eastern Ave. Date signed 10/6/47

G55745 BC# 46318

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G55745 Registered No. 108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 272 Dallas Court
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 31.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 272 Dallas Court
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Robert August (OR AUGUSTYNIAK)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-5-1946

8. AGE: Years	Months	Days	If less than one day
0	11		hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Joseph August
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Catherine Mach
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Catherine August
(b) Address 272 Dallas Court

17 (a) Burial (b) Date thereof 10-8-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rozary
Location Baltimore Md.

18 (a) Funeral director George A Weber
(b) Address 705 South Ann Street

19 (a) (Date rec'd by registrar) (b) Registrar Washington Baltimore

OCT 6 1947

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5th 1947, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-5- 1947, to 10-5- 1947, and that I last saw h-- alive on 10-5- 1947.

Immediate cause of death	Duration
Pneumonia, Lobar, Bilateral	1 day
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry E. Morey M.D.
M. D.
Address 408 N. Lafayette Ave Date signed 10-6-47

G55746 BALTIMORE CITY HEALTH DEPARTMENT ✓ G55746

Bl#990395 **CERTIFICATE OF DEATH** 160a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Provident Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1624 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Geraldine Thomas

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Negro	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-27-47

8. AGE: Years	Months	Days	If less than one day
		8	hr. min.

9. Birthplace 1824 W. Lanvale St. Baltimore Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Edward Kea
13. Birthplace Bethel N. C.

MOTHER
14. Maiden Name Louise Thomas
15. Birthplace Balto. Md.

16 (a) Informant Charles Edward Kea
(b) Address 1310 Mulberry St

17 (a) Burial (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Balto. Co.

18 (a) Funeral director Mrs. George F. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) 6 1947 (b) Washington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 5 1947, at 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 3 1947 to Oct 5 1947, and that I last saw h. alive on Oct 5 1947.

Immediate cause of death	Duration
Intracranial injury	
Due to Birth injury	
Due to Breech delivery	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature G. L. Banjuer M. D.
Address 7227 N. Fulton Ave Date signed 10-6-47

Correct age is especially important. Physicians, please write.

VS 150

G55747

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G55747

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo 26dys
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2300 E. BALTIMORE ST.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ignatius (~~JAROWSKI~~) JAROWSKI

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race W

6 (a) ~~Single, married~~, widowed, ~~or divorced~~ W Widowed

6 (b) Name of husband or wife PAULINE

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 11/2/1892

8. AGE: Years 64 | Months 11 | Days 1 | If less than one day ____ hr. ____ min.

9. Birthplace WILNO, POLAND
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name FELIX JAROWSKI
13. Birthplace WILNO, POLAND

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace POLAND

16 (a) Informant MR. CHARLES JAROWSKI
(b) Address 2300 E. BALTIMORE ST.

17 (a) BURIAL (b) Date thereof 11/7/47.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory MORELAND MEMORIAL
Location TAYLOR AVE.

18 (a) Funeral director M. F. JAROWSKI & SONS
(b) Address 1808 EASTERN AVENUE

19 (a) ____ (b) ____
(Date received by registrar) Thursday Nov 6 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 3 1947, at 9:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-14-47, to 10-3 1947 and that I last saw h[illegible] alive on 10-3-47 19____

Immediate cause of death	Duration
Heart failure	
Due to diabetic gangrene	3 years
Due to [illegible]	
Other Conditions [illegible]	

(Include pregnancy within 3 months of death)

Date of operation 9-29-47

Major findings of operation: Amputation of right foot and debridement of [illegible]

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 10-3-47

G55748 BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 94a G55748

1. PLACE OF DEATH:
(a) [redacted]
(b) [redacted] Atlantic Ocean
(c) [redacted] M.S. Yvonne
Pronounced dead on September 29, 1947 at 3:15 A.M.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) Country Brazil
(c) City or town Sao Paulo
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rua Itapeva 700
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Brazilian by Decree September 5, 1941

3 (a) FULL NAME HERBERT JAMES SINGLETON BOYES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elvira

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) October 16, 1881

8. AGE: Years	Months	Days	If less than one day
65	11	13	hr. min.

9. Birthplace Swinton, Manchester, England
(Town, county, and state)

10. Usual Occupation Industrial Mill Owner

11. Industry or business

FATHER
12. Name Simeon Boyes
13. Birthplace England

MOTHER
14. Maiden Name Edna Singleton
15. Birthplace England

16 (a) Informant Mrs. Elvira Boyes
(b) Address Rua Itapeva 700 Sao Paulo, Brazil

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct. 10, 1947 (month) (day) (year)

(c) Cemetery or crematory Consolacao
Location Sao Paulo, Brazil

18 (a) Funeral director Bertrand Rose
(b) Address 2224 N. Charles Street

19 (a) [redacted] (Date received by registrar) (b) Thurlington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION official A.

20. DATE OF DEATH October 2 19 47, at 11:50 M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 10-2-47

X

G55749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

✓ G55749 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1007 Somerset Alley
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Person.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

Sex Male | Color or race Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-31-93

8. AGE: Years 54 | Months —1 | Days —5 | If less than one day —hr. —min.

9. Birthplace N.C (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Rufus Person
13. Birthplace N.C

MOTHER 14. Maiden Name Ella Fuller
15. Birthplace N.C

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 10-9-47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Hendersonville, N.C.

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

Thurlington for Williams Mfg. Co.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-5-47, 8:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-31-47, to 10-5-47, and that I last saw him alive on 10-5-47.

Immediate cause of death Asphyxia	Duration
Due to Carcinoma of esophagus invading	
Due to Cachexia	
Other Conditions Gastrostomy	

(Include pregnancy within 3 months of death)

Date of operation Gastrostomy - Oct 1, 47

Major findings of operation:

of autopsy: 2nd day

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Victor A. McKusick M. D.
Address Johns Hopkins Hosp. Date signed 10/6

X

G55750 BALTIMORE CITY HEALTH DEPARTMENT G55750
CERTIFICATE OF DEATH 937 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2925 West North Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2925 West North Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE BECKER

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Divoriced
6 (b) Name of husband or wife Mary Becker
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1879
8. AGE: Years 68 | Months | Days | If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name Frederick Becker
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name M. Eliz. Braun
15. Birthplace Balto., Md.

16 (a) Informant Mrs. R. Albert
(b) Address 525 East 22nd Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-7-47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director WIEDEFELD AND SON
(b) Address GREENMOUNT AVE & 22ND
(c)

OCT 6 1947 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4th 1947, at 9:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1947, to Oct 4 1947, and that I last saw h-- alive on Sept 25 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	3 d.
Due to Hypertensive Cardio Vascular disease	10-15 yrs
Due to Chronic Nephritis Cerebral hemorrhage	2-3 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daniel R. Robinson M. D.
Address 2835 Guilford Ave Balto Md Date signed 10-6-47

Daniel R. Robinson X

G55751

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G55751

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton + Wilkens Avenues
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. Reisterstown Rd., Md.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1867

8. AGE: Years	Months	Days	If less than one day
80	1	21	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Farming

11. Industry or business

FATHER
12. Name John Smith
13. Birthplace Md. Ireland

MOTHER
14. Maiden Name Winnifred Egan
15. Birthplace Md. Ireland

16 (a) Informant Reinfred Smith
(b) Address Reisterstown

17 (a) Burial (b) Date thereof Oct 9-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Balto Co

18 (a) Funeral director J. F. Elene. Sons
(b) Address Reisterstown Md

19. (a) 1947 (b)
(Date rec'd by registrar) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/6 1947, at 2:35 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/26 1947 to 10/6 1947 and that I last saw h[illegible] alive on 10/6 1947

Immediate cause of death	Duration
Terminal hypostatic pneumonia	
Due to Cerebral hemorrhage, right	10 days
Due to Arteriosclerotic cardiovascular disease	7
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert J. Brockas

Address St Agnes Hosp Date signed 10/6/47
M. D.

X

G55752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G55752 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 608 E. Madison St
(c) Hospital or institution:
10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 608 E. Madison St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Williams

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife Harmon Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1857

8. AGE: Years	Months	Days	If less than one day
90	9		hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name Enfin Barnes
13. Birthplace Va

MOTHER
14. Maiden Name Anna Taylor
15. Birthplace Va

16 (a) Informant Sydney Musl
(b) Address 608 E Madison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-8-47 (month) (day) (year)
(c) Cemetery or crematory Lillian Va
Location Va

18 (a) Funeral director Geo. E. Kelson
(b) Address [illegible]

19 [illegible] (Date rec'd by registrar) [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1947, at 4. A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1 - 1947 to 10/6 1947
and that I last saw h[illegible] alive on 10/6/1947
The immediate cause of death Bronchio Pneumonia — Duration 7 days
Due to Colds & Exposure
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Jas. R. Blake M.D.
Address 1327 N. Central Ave Date signed 10/7/47

VS 150

5753 BALTIMORE CITY HEALTH DEPARTMENT 937 655753

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) 11

2. USUAL RESIDENCE OF DECEASED:
(a) State Texas (b) County Potter
(c) City or town Amarillo
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2215 Hughes St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Cowan

3 (b) If veteran, name war: 1 WW
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Lourena
6 (c) If alive, give age 48 years
7. Birth date of deceased (mo., day, yr.) 2-17-85
8. AGE: Years 62 Months 7 Days 9 If less than one day ____ hr. ____ min.
9. Birthplace Texas (Town, county, and state)
10. Usual Occupation Drug Co - Sec
11. Industry or business Water Works

FATHER
12. Name Andrew Cowan
13. Birthplace Scotland

MOTHER
14. Maiden Name Elizabeth Sterling
15. Birthplace Scotland

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Removal (b) Date thereof Oct 6-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Llano
Location Amarillo Texas
18 (a) Funeral dir. Ray B Wilson Funeral Home
(b) Address 403-E-7th St
1947 6 1947 Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1947 at 2 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 24 1947 to Oct 6 1947 and that I last saw h alive on Oct 6 1947

Immediate cause of death Uremia — Duration
Due to Cardiac failure
Due to Hypertensive Cardio-vascular disease
Other Conditions Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marion B Sloan M. D.
Address Johns Hopkins Hosp Date signed Oct 7

754

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G55754
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 Stony Run Lane
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Parkville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 33 Longmore (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Monde F Kilsey

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife William A Kilsey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30 1870

8. AGE: Years 77 | Months 2 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name David K. Gallehofer
13. Birthplace Carroll Co Md
14. Maiden Name Virginia Price
15. Birthplace Baltimore Md

16 (a) Informant Elizabeth C Kilsey
(b) Address 2742 Riggs Ave

17 (a) Funeral (Burial, cremation, or removal) (b) Date thereof 10/5/47 (month) (day) (year)
(c) Cemetery or crematory Ft Lincoln
Location Washington D C

18 (a) Funeral director Gilford Dove
(b) Address 5217 Pearl

Date rec'd by registrar 10 6 1947 Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1947, at 1 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 2 1947 to Oct. 6 1947 and that I last saw h alive on Oct 6 1947

Immediate cause of death Cerebral Hemorrhage — Duration 2-6 hrs

Due to Arteriosclerosis & Hypertension —

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stevenson A Jones M.D.
Address Med Arts Bldg. Date signed Oct 7-47.

5753

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. C55755

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 318 Ilchester Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Clayton M. Pike

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-03-4021

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Eleanor Pike
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 7th 1888

8. AGE: Years	Months	Days	If less than one day
59	1	29	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Enterprise Roofing Co.

FATHER
12. Name James T. Pike
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Sarah R. German
15. Birthplace Balto. Md.

16 (a) Informant Eleanora Pike
(b) Address 318 Ilchester Ave

17 (a) Burial (b) Date thereof 10/9/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) [illegible] 1947 (b) Registrar Huntington Williams M.D.

Correct age if deceased is under one year or over 100

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/6 1947, at 6 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/2 1947, to 10/6 1947, and that I last saw him alive on 10/6 1947.

Immediate cause of death	Duration
Respiratory Failure	
Due to: Bronchopneumonia	1 wk.
Due to	
Other Conditions Generalized Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry J. Hourihan M. D.
Address 320 Jos. J. Hoff. Date signed 10/6/47

5756

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G55756 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2833- Harlem Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2833- Harlem Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE W. RIGGIN

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-2965

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Almira Riggin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 7th 1882

8. AGE: Years	Months	Days	If less than one day
65	1	29	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Guard
11. Industry or business War Assets Administration

FATHER
12. Name Geo Riggin
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Emma Kelley
15. Birthplace Balto. Md.

16 (a) Informant Almira Riggin
(b) Address 2833 Harlem Ave

17 (a) Burial (b) Date thereof 10/9/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Williams Cook Inc.
(b) Address 1217 St. Paul St.

OCT 6 1947 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6, 1947, at 9.15 a M

21. I certify that I took charge of the remains described above, held an Inspection + Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George C. Merrill M.D.
Medical Examiner.
Date signed 10-6-47

757

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G55757 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 823 N. Milton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 823 N. Milton Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles L. Sonberg

3 (b) If veteran, name war	3 (c) Social Security Account No.
	216-01-8448 A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6, 1880

8. AGE: Years	Months	Days	If less than one day
67	6	28	hr. min.

9. Birthplace Czechoslovakia
(Town, county, and state)
10. Usual Occupation Baker
11. Industry or business Vidali's Bakery

FATHER
12. Name James Sonberg
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Anna Pecha
15. Birthplace Czechoslovakia

16 (a) Informant Mrs. Emma Tyburec - Neice
(b) Address 823 N. Milton Avenue

17 (a) Burial (b) Date thereof 10/7/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Horner's Lane, Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03-05 E. Madison St.

19 (a) Oct 8 1947 (b) [illegible]
(Date rec'd by Registrar)

VS 190 –

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4 1947, at 5.50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 22 1943 to Oct. 4 1947 and that I last saw him alive on Oct. 4 1947.

Immediate cause of death	Duration
Cerebral Thrombosis	7 days
Due to Arteriosclerosis	
Due to	
Other Conditions Hypertension + Hypertensive Heart	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Vincent J. Zoska M.D.
M. D.
Address 845 N. Patt. Pl. Bty Date signed 10/7/47

X

5758

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 192 B

G55758
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2027 Druid Hill Ave
(c) Hospital or institution:
14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 2027 Druid Hill Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Louise Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: colored
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9, 1908

8. AGE: Years 39 | Months 3 | Days 25 | If less than one day hr. min.

9. Birthplace VA
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs Lottie Willis
(b) Address 2027 Druid Hill Ave

17 (a) Burial (b) Date thereof 10-9-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Frank Frazier A. Hensley
(b) Address 378 W. Biddle St.

19 (a) OCT 7 1947
(Date rec'd by registrar) Huntington Williams, M.D.

correct age is especially important. Physicians, please

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4 1947, at 2:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 24 1947, to Oct 4 1947 and that I last saw h[illegible] alive on Oct 4 1947.

Immediate cause of death: Ventricular Insufficiency — Duration

Due to Edema

Due to Large fibroid tumor of uterus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature V. Edward Fisher M. D.
Address 1209 Monument Date signed Oct 6/47

X

5759

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1.132

Registered No. G55759

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1061 W. Fayette St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1061 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRIETTA H. JACKSON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 22, 1925

8. AGE: Years	Months	Days	If less than one day
22	10	12	hr. min.

9. Birthplace South Carolina
(Town, county, and state)
10. Usual Occupation Domestice
11. Industry or business

FATHER
12. Name Henry Jackson
13. Birthplace S. C.

MOTHER
14. Maiden Name Lucielle McNiel
15 Birthplace S. C.

16 (a) Informant Mrs. Anna McNeil
(b) Address 1061 W. Fayette St.

17 (a) Burial (b) Date thereof 10-8-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

OCT 7 1947 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

V S 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH October 4, 1947, at 2:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1946, to Oct 4 1947, and that I last saw [illegible] alive on Oct 3 1947.

Immediate cause of death Pulmonary T.B. C. — Duration

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 2530 - Pa. Ave., Date signed 10/6/47

X

760 BCH B62145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157H

Registered No. G55760

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5
(c) Hospital or institution: Sinai Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life time

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2407 Ellamont st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH F. LONG

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced. —
6 (b) Name of husband or wife —
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr) 11 13 1946
8. AGE: Years | Months 10 | Days 21 | If less than one day ..... hr. ..... min.
9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation
11. Industry or business —

FATHER
12. Name Jr Charles Long
13. Birthplace Balto Md

MOTHER
14. Maiden Name Arline V. Farland
15. Birthplace Providence Rhode Island

16 (a) Informant Charles Long
(b) Address 2407 Ellamont st

17 (a) (Burial, cremation, or removal) (b) Date thereof 10 7 46 (month) (day) (year)
(c) Cemetery or crematory [redacted] 10 7 46
Location New Cathedral Cem

18 (a) Funeral director A. Jones
(b) Address 501 Arlington Ave Park
OCT 7 1947 Huntington Williams (Registrar)
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/4 1947, at 12 Noon M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 17 1947 to Oct 4, 1947, and that I last saw him alive on 10/4 1947.

Immediate cause of death: Bronchopneumonia
Uremia
Due to: ung. Metat Hydrocephalus
Due to: Block in bronchial tree

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [redacted] M. D.
Address Sinai Hosp Date signed 10/4/47

X

55761 — S-355761

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 764 W. Saratoga St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 - 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 764 W. Saratoga St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Smiley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22, 1907

8. AGE: Years	Months	Days	If less than one day
40			hr. min.

9. Birthplace Lancaster Co. Va. (Town, county, and state)
10. Usual Occupation Factory Employee
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Va

MOTHER
14. Maiden Name Unknown
15. Birthplace Va

16 (a) Informant Elmira Smiley
(b) Address 764 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-10-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location Cedar Hill Md.

18 (a) Funeral director Adolphus Halsted
(b) Address 918 Druid Hill Ave.

OCT 8 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-6 1947 at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1947 to Oct 6 1947 and that I last saw h[illegible] alive on Oct 6 1947

Immediate cause of death	Duration
Coronary Thrombosis	2 hrs
Due to Arteriosclerosis	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 764 W. Saratoga St. Date signed 10-7-47

5762

GM. 114084

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G55762
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 143 N. Colvin ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Graham Parrish

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Alice
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 7 -1907

8. AGE: Years	Months	Days	If less than one day
40	-	26	hr. min.

9. Birthplace N.C.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Andrew
13. Birthplace N.C.

MOTHER
14. Maiden Name Lola Michum
15. Birthplace N.C.

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Removal (b) Date thereof Oct 8 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Durham N. Carolina

18 (a) Funeral director Mrs Pott A. Eckard Dept.
(b) Address 1129 N. Carlin St

Oct 7 1947 (b) Hunting for Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3 - 1947, at 11.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 25- 19 47 to Oct. 3 - 19 47, and that I last saw h im alive on Oct. 3 - 1947

Immediate cause of death	Duration
Bilateral Pulmonary Thrombosis	1 wk
Due to Pulmonary Infarction ?	
Bilateral Contusion Rt.	
Due to	
Other Conditions Hypertrophic Arteriosclerotic Card. Dis. Radic Prostatectomy	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Seagle W. Parker M. D.
Address City Hosp. Balto Date signed 10-6-47

CONCEAL ENTIRE IF CERTIFICATE IS INCOMPLETE

5763

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. 65763

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Marlborough Apts.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Aaron Folb

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mignon B. Folb
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13 1892

8. AGE: Years	Months	Days	If less than one day
55	2	22	hr. min.

9. Birthplace North Carolina
(Town, county, and state)
10. Usual Occupation Nurse
11. Industry or business

FATHER
12. Name Michael Folb
13. Birthplace Germany

MOTHER
14. Maiden Name Rosa Greenhood
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Mignon B. Folb
(b) Address Marlborough Apts

17 (a) Burial (b) Date thereof 10/7/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director David Sondheim & Son
(b) Address 1902 Eutaw Place

OCT 7 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/5 19 47 at 2:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/5 1947 to 10/5 1947 and that I last saw h. 10 alive on 10/5 1947

Immediate cause of death Cardiac failure & respiratory failure — Duration 4 hours

Due to Coronary insufficiency & Myocardial infarction

Other Conditions Pulmonary edema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Friedman M. D.
Address Sinai Hosp Date signed 10/5/47

7571

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G55754

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Alleg
(c) City or town Cumberland (If outside city or town limits, write RURAL and give town)
(d) Street No. 718 Bedhardt Dr. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Thiede

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/4/85

8. AGE: Years 62 | Months 3 | Days 2 | If less than one day ____ hr. ____ min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation

11. Industry or business James Thomas

FATHER — 12. Name Thomas James
13. Birthplace Ind

MOTHER — 14. Maiden Name Jane S Chamsow
15. Birthplace Ind

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-7-47 (month) (day) (year)
(c) Cemetery or crematory TOLEDO MEMORIAL PARK
Location TOLEDO (OHIO)

18 (a) Funeral director John O Mitchell
(b) Address 1860 Euclid Ave

OCT 7 1947 (Date rec'd by registrar) (b) Willis Huntington Williamsport Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/6 1947, at 3:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/4 1947 to 10/6 1947 and that I last saw her alive on 10/6 1947.

Immediate cause of death	Duration
Due to Carcinoma of breast & undetermined	
Due to metastases	2 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Andrew B. Morrow M. D.
Address JHH Date signed 10-8-47

X

5765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

G55765
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3826 Barrington Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3826 Barrington Road
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Eva Elmer Phillips

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Harry D. Phillips
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1880

8. AGE: Years	Months	Days	If less than one day
66	11	--	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name George H. Elmer
13. Birthplace Pittsburg, Pa.

MOTHER
14. Maiden Name Henrietta Langrall
15. Birthplace Pittsburg, Pa.

16 (a) Informant Harry D. Phillips
(b) Address 3826 Barrington Road

17 (a) Burial (b) Date thereof 10/7/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

OCT 7 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

correct age is especially important. Typewriter preferred.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 1947 to Oct 5 1947, and that I last saw h[illegible] alive on Oct 5 1947.

Immediate cause of death Bronchitis
Asthma
Duration 8 yrs.

Due to

Due to

Other Conditions Arteriosclerotic Heart Disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature John A Evans M. D.
Address 612 W. 40th St. Date signed

112

5766

G55768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4909 Eastern Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Co.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4909 Eastern Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gottfried Gotthold Schlaile

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15th 1866

8. AGE: Years	Months	Days	If less than one day
81	-	19	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

MOTHER FATHER

12. Name —

13. Birthplace Germany

14. Maiden Name —

15. Birthplace Germany

16 (a) Informant John Schlaile

(b) Address 4909 Eastern Ave

17 (a) Burial (b) Date thereof Oct 7th 1937
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Morelands

Location Taylor Ave

18 (a) Funeral director Leo G. Cook

(b) Address 1201-03 N. Patterson Park av

19 OCT 7 1937 (Date rec'd by registrar) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/7 1937, at 1 P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.

Date signed 10/7/37

767

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G557567 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4302 Granada Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4302 Granada Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN THOMAS COX

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Alice R. Cox
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1870

8. AGE: Years	Months	Days	If less than one day
77	7	25	hr. min.

9. Birthplace Balto. Co., Md.
(Town, county, and state)
10. Usual Occupation Baker
11. Industry or business Koester's Bakery

FATHER
12. Name William Cox
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden Name -
15. Birthplace

16 (a) Informant Mr. Wm. P. Cox
(b) Address 4302 Granada Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 7 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1947 to Oct 6th 1947 and that I last saw h[illegible] alive on Oct 5th 1947.

Immediate cause of death	Duration
Cerebral Embolism	3 days
Due to Myocarditis	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. E. Boulton
Address 3304 Fenwick Blvd Date signed 10th D. 10/7/47

5768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G55768 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2940 Clifton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2940 Clifton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALICE J. RAMSEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Joseph L. Ramsey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 1, 1871

8. AGE: Years	Months	Days	If less than one day
76	7	4	hr. min.

9. Birthplace Friendship, A. A. Co., Md.
(Town, county, and state)
10. Usual Occupation -
11. Industry or business

FATHER
12. Name Wm. W. Ward
13. Birthplace A. A. Co.

MOTHER
14. Maiden Name Mary Jane Wells
15. Birthplace A. A. Co.

16 (a) Informant Mr. Stephen Leitch
(b) Address Windsor Court Apts.

17 (a) Burial (b) Date thereof 10/8/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5 1947, at 3:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 11 1947 to Oct 5 1947, and that I last saw h[illegible] alive on Oct 5 1947.

Immediate cause of death	Duration
Lobar pneumonia	4 days
Due to	
Due to	
Other Conditions Paralysis Agitans	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Ernest F. Lellue M. D.
Address 1730 Bolton St Date signed 10/6/47

V S 190

5769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1497

Registered No. 655769

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3135 N. Calvert St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3135 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGRETTA H. ALFORD

3 (b) If veteran, name war –
3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 29, 1877

8. AGE: Years	Months	Days	If less than one day
69	11	5	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Schoolteacher (retired)
11. Industry or business

FATHER
12. Name George C. Alford
13. Birthplace Baltimore

MOTHER
14. Maiden Name Clara R. Jacobs
15. Birthplace Baltimore

16 (a) Informant Mr. George C. Alford
(b) Address 82 Woodington Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/7/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) OCT 7 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4, 1947, at 10.19 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 22 1947 to Oct 4 1947, and that I last saw her alive on Oct 3 1947.

Immediate cause of death	Duration
Cachexia & Dehydration	Several mos.
Due to Carcinoma of Rectum	1 yr + 2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Carroll Lockard M. D.
Address 2925 N. Charles Date signed 6 Oct 47

55770

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G55770 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Paul & 32nd St.
(c) Hospital or institution:
Jefferson Apts. 17

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
St. Paul & 32nd St.
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN JAMES FRASER

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary J. Fraser
6 (c) If alive, give age 86 years

7. Birth date of deceased (mo., day, yr.) Sept. 24, (illegible)

8. AGE: Years	Months	Days	If less than one day
(illegible) 86	0	11	hr. min.

9. Birthplace Nova Scotia
(Town, county, and state)
10. Usual Occupation -
11. Industry or business

FATHER
12. Name William Fraser
13. Birthplace Scotland

MOTHER
14. Maiden Name Mary McTaish
15. Birthplace Scotland

16 (a) Informant Mrs. Mary J. Fraser
(b) Address Jefferson Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (illegible) rec'd by Registrar (b) Huntington Williams, M.D. Registrar

Correct age is especially important

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 5, 1947, at 7:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/29/1937, to 10/5/1947, and that I last saw him alive on 10/5/1947.

Immediate cause of death	Duration
Cardiovascular Hypertension, heart disease	7 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Samuel Morrison, M.D.
Address 11 E. Chase St. Date signed 10/8/47

City 2

5771 /

CM. 114130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V. 13B

Registered No. G55771

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals 9

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 7 Days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 917 Cator Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Edward Mooney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 11 - 1888

8. AGE: Years	Months	Days	If less than one day
58	9	23	hr. min.

9. Birthplace MD. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Edward P. Mooney

13. Birthplace Baltimore

MOTHER

14. Maiden Name Margaret Trainer

15. Birthplace Baltimore

16 (a) Informant Records Balt. City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 8 47 (month) (day) (year)

(c) Cemetery or crematory New Cath. Location Old Frederick Rd.

18 (a) Funeral director Wm. J. Moran

(b) Address 429 Lexington

19 OCT 7 1947 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4 - 1947 at 1.35P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 27 19 47 to Oct. 4 - 19 47 and that I last saw him alive on Oct. 4 - 19 47.

Immediate cause of death T.B. Meningitis — Duration 2 weeks

Due to Pulmonary T.B., ulcerative — 28 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible] M. D.

Address Balto City Hosp. Date signed 10/4/47

5772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G55772

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Darlington (If outside city or town limits, write RURAL and give town)
(d) Street No. Darlington Rd (If rural, give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Elizabeth Smith Thomas

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 10/6/82

8. AGE: Years 64 years | Months 11 | Days 28 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland (Town, county, and State)
10. Usual Occupation Housewife Retired
11. Industry or business School - Asst. Principle

FATHER
12. Name Charles F. Thomas
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Rebecca S. Edge
15. Birthplace Pennsylvania

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-7-1947 (month) (day) (year)
(c) Cemetery or crematory Darlington Burying Ground
Location Darlington, Harford Co., Md.

18 (a) Funeral director Stewart & Mowen Company
(b) Address (W. J. Wooden - owner) 103 W. North Ave. City.

19 (a) 10 8 47 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4 - 1947, at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/8 1947 to 10/4 1947, and that I last saw her alive on 10/4 1947.

	Duration
Immediate cause of death: Intraperitoneal Abscess	?
Due to: Thoraco-abdominal exploration, left for	3 wks.
Due to: suspected carcinoma of stomach	
Other Conditions: Polycythemia vera	2 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: No pathology
of autopsy: Intra abdominal abscess

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature
Address Andrew G. Mowen, M.D. Date signed 10-9-47

JHD. X

5773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G55773
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4339 Shamrock Avenue
(c) Hospital or institution:
Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4339 Shamrock Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE WINFIELD BLOODSWORTH

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	212-12-5252

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Rosa Ella Bloodsworth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov-2-1866

8. AGE: Years	Months	Days	If less than one day
80	11	4	hr. min.

9. Birthplace Mt. Vernon, Maryland
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Carpenter

FATHER
12. Name Littleton Bloodsworth
13. Birthplace Mt. Vernon, Maryland

MOTHER
14. Maiden Name Lucietia Murrell
15. Birthplace Mt. Vernon, Maryland

16 (a) Informant Mrs. Ethel Sterlock (daughter)
(b) Address 2806 Louise Ave. City #14

17 (a) Burial (b) Date thereof Oct-9-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Presbyterian
Location Princess Anne, Maryland

18 (a) Funeral director Stewart & Mowen Company
(b) Address 106 N. North Avenue, City #1.

19 (a) [illegible] Williams M.D.
(Date rec'd by registrar) Registrar

correct age is especially important. Physicians: please write plainly.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/4 at 5a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/10th 1944, to 9/27th 1947. and that I last saw h[illegible] alive on 9/27th 1947.

Immediate cause of death	Duration
Cardiac failure,	10 days
Due to Cardiac Decompensation	2
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Faulkner M. D.
Address 100 N. Milton Ave Date signed 10/6/47

X

774 BCH 93 90586

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G55774

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto City
(c) City or town Baltimore City
(If outside city or town limits write RURAL and give town)
(d) Street No. 32 Murdock Rd. City #12
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country.....

3 (a) FULL NAME Baby Boy Hayden (James Thomas Hayden)

3 (b) If veteran, name war / 3 (c) Social Security Account No.

4. Sex male | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/30/47

8. AGE: Years | Months | Days 6 dys | If less than one day hr. ..... min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation infant
11. Industry or business

FATHER 12. Name Weldon C. Hayden
13. Birthplace Leonardtown - Md

MOTHER 14. Maiden Name Catherine V. Simms
15. Birthplace Wash. D.C.

16 (a) Informant Weldon C. Hayden (father)
(b) Address 32 Murdock Rd. City-#12

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-8-47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto. Md

18 (a) Funeral director Leonard Sparrow Co
(b) Address 1010 N. Eutaw Ave

19 Oct 9 1947 (Date rec'd by Registrar) (b) Huntington Williams M.D. (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1947, at 11:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 30 1947 to Oct 6 1947, and that I last saw him alive on Oct 6 1947

Immediate cause of death	Duration
Respiratory distress	
followed by cardiac failure	
Due to Cause unknown	
Due to	
Other Conditions Prematurity	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?.....
(e) Means of injury.....
23. Signature J Brumback M. D.
Address University Hosp Date signed 10/6/47

correct age is especially important. Typewriter, please.

5775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G55775

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 619 N. Madeira St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 619 N. Madeira St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma E. Neubert

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Bardeau Neubert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 11-1873

8. AGE: Years	Months	Days	If less than one day
72	11	25	hr. min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Emma Stranick
(b) Address 636 N. Chester St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 8-47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Co. Location North Ave. & Gay St.

18 (a) Funeral director John F. McGlen
(b) Address 2834 Jefferson St.

19 (a) OCT 7 1947 (Date received by registrar) (b) Huntington Williams, M.D.

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5 1947, at 4:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1946 to Oct 1947, and that I last saw h.. alive on Oct 5 1947.

Immediate cause of death	Duration
Pulmonary edema	3-4 days
Due to Coronary Thrombosis	1 yrs.
Due to Arteriosclerosis	3-4 yrs.
Other Conditions Diabetes.	5 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Reuben H. Kolman
Address 3700 Park Heights Ave. Date signed Oct 9 1947

94a

55778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

655778 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1735 Clarkson St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emma B Tang

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: George Tang
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec 25, 1890

8. AGE: Years: 50 | Months: 1 | Days: 6 | If less than one day: hr. min.

9. Birthplace: Balto Md (Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business

FATHER
12. Name: Matthew Selster
13. Birthplace: Don't know

MOTHER
14. Maiden Name: " "
15. Birthplace: " "

16 (a) Informant: George Tang
(b) Address: 1738 Clarkson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 8, 1947 (month) (day) (year)
(c) Cemetery or crematory: Holy Cross
Location: A. 66

18 (a) Funeral director: A. Howard Evans
(b) Address: 1410 Lafayette St

19 (a) [illegible] (Date received by Registrar) (b) Huntington for Williams, M.D. Registrar

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/4 1947, at 5:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: 2nd - 3rd degree burns
90% body
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 23/3
(a) Date of injury 10/3/47 at about 6:00 A.M.
(b) Where did injury occur? 1738 Clarkson St
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Stove explosion at home

23. Signature: C. C. Lieberman M.D. Medical Examiner.
Date signed 10/5/47

5777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

✓ 655777 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1827 Hanover St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1827 Hanover
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary M. Van Bulen Suesse

3 (b) If veteran, name war No | 3 (c) Social Security Account No. No

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife August Suesse
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1, 1881

8. AGE: Years 66 | Months 9 | Days 4 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Frank Schuch
13. Birthplace Germany

MOTHER
14. Maiden Name Dont know
15. Birthplace Dont know

16 (a) Informant Frank Van Bulen
(b) Address 707 Church St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 9 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto City

18 (a) Funeral director C. Oswald Byrnes
(b) Address 1440 St Paul St

19 OCT 7 1947 (Date rec'd by registrar) (b) Burial Permit No. Williams MD

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5 1947, at 9:40a M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 27 1947 to Oct 5 1947, and that I last saw h[illegible] alive on Oct 1947

Immediate cause of death	Duration
acute Edema of lungs	2 ds
Due to Cerebral Hemorrhage	4 ds.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. E. Campbell M.D.
Address 164 Hanover Date signed 10/6/47

5778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 655778

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 427 East Lyon Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 80yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 427 East Lyon Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Luanna Jennie Harden Donaldson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: late Louis T.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 18 1863

8. AGE: Years 84 | Months - | Days 8 18 | If less than one day hr. min.

9. Birthplace Howard Co Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Harden
13. Birthplace Md

MOTHER
14. Maiden Name Caroline Wolfe
15. Birthplace Md

16 (a) Informant Miss Beatrice Donaldson
(b) Address 427 East Lyon Ave

17 (a) Buried (b) Date thereof Oct. 10, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location 3445 Frederick Ave

18 (a) Funeral director Agney H. Wright
(b) Address 4101 Edmondson Ave

19 (a) OCT 7 1947 (b) Huntington Williams M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1947, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1947 to Oct 1947 and that I last saw h.e.r alive on Oct 5 1947

Immediate cause of death: Arteriosclerotic coronary thrombosis — Duration 1 yr.

Due to

Due to

Other Conditions Cerebral Hemorrhage

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M.D.

Address 2030 Wilkens Ave Date signed 10/7/47

55779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

✓ G55779 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount Ave.
(c) Hospital or institution:
Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 515 N. Chapelgate Lane
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME August Giesecke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced
Male	White	~~Married~~ Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 6, 1873

8. AGE: Years	Months	Days	If less than one day
74	8	-	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Louis Giesecke
13. Birthplace Germany

MOTHER
14. Maiden Name Maria Seegers
15. Birthplace Germany

16 (a) Informant August Giesecke
(b) Address 515 N. Chapelgate Lane

17 (a) Cremation (b) Date thereof Oct 10/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount & Ohrer

18 (a) Funeral director Henry H. Witzke
(b) Address 1101 E Monument Ave.

19 (a) OCT 7 1947 (b) Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6 19 47 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 4 1947 to Oct. 6 1947, and that I last saw him alive on Oct. 6 1947.

Immediate cause of death	Duration
~~Cerebral Hemorrhage~~ Terminal bronchopneumonia	
Due to	
Due to	
Other Conditions ~~Terminal~~ Cerebral Thrombosis (Include pregnancy within 3 months of death)	3 days

Date of operation
Major findings of operation:
of autopsy: Confirms diagnosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Robert Haase M. D.
Address Church Home & Hosp. Date signed 10/6/47

107

55780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G55780

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun Sts
(c) Hospital or institution:
Franklin Square Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Balt. Md. County Baltimore
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4300 Welborne Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Schwanebeck

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Late Frederick W
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 1, 1877

8. AGE: Years	Months	Days	If less than one day
70	7	4 3	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Conrad Koentzler
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Plasse
15. Birthplace Germany

16 (a) Informant Henry H Schwanebeck
(b) Address 4300 Welborne Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 7 1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location 3801 Frederick Rd

18 (a) Funeral director Henry H Wight
(b) Address 4101 Edmondson Ave

19 (a) [illegible] (b) Huntington Williams Mfg

Correct age is especially important if under 1 year or over 65

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 Oct. 1947, at 1.25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 27 Sept 1947 to 4 Oct 1947, and that I last saw her alive on 4 Oct. 1947.

Immediate cause of death	Duration
Pulmonary infarcts	
Due to Thrombosis of Femoral Vein	
Due to Trauma & fracture of rt. hip.	
Other Conditions Arteriosclerosis nephrosclerosis	

(Include pregnancy within 3 months of death)

Date of operation 1 Oct. 47
Major findings of operation: Fractured rt. hip.
of autopsy: Pulmonary infarcts.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 9/27/47 at [illegible] M
(c) Where did injury occur? 4300 Welborne Ave [illegible] Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Fell down stairs
23. Signature Vincent A. Lacace
Address Franklin Sq. Hosp. Date signed 4 Oct '47 M. D.

Honora J. Sheridan, M.D.

5781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a ✓

Registered No. G55781

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 627 Linnard St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 627 Linnard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Charles Schlickenmaier

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Alice R. Schlickenmaier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 22, 1891

8. AGE: Years 56 | Months 1 | Days 14 | If less than one day: hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Hauling
11. Industry or business

FATHER 12. Name John Schlickenmaier
13. Birthplace Md.

MOTHER 14. Maiden Name Anna Buchwald
15. Birthplace Md.

16 (a) Informant Mrs. Alice R. Schlickenmaier
(b) Address 627 Linnard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 9/47. (month) (day) (year)
(c) Cemetery or crematory Louden Park
Location 3801 Frederick Ave.

18 (a) Funeral director Harry H. Mikkle
(b) Address 4101 Edmondson Ave.

19 (a) OCT 7 1947 (Date rec'd by registrar) Washington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6/47. 19 , at 6 30 A M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1946 to Oct. 6, 1947. that I last saw him alive on Oct. 5, 1947.

Immediate cause of death: Coronary Thrombosis — Duration 15 hrs.
Due to
Due to
Other Conditions Hypertension — 18 mos.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. E. Wellen M. D.
Address 4100 Edmondson Ave Date signed 10/6/47

X

5782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

Registered No. 655782

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4105 Roland Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4105 Roland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DANIEL L. SENFT

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	216-05-0358

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	widower

6 (b) Name of husband or wife Helen Reckord Senft
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13, 1885

8. AGE: Years	Months	Days	If less than one day
62	2	23	hr. min.

9. Birthplace Westminster, Md.
(Town, county, and state)
10. Usual Occupation Canton Lumber Co.
11. Industry or business

FATHER
12. Name Milton Senft
13. Birthplace Pa.

MOTHER
14. Maiden Name Alretta Zepp
15. Birthplace Westminster, Md.

16 (a) Informant Mr. Daniel L. Senft, Jr.
(b) Address 4105 Roland Ave.

17 (a) Burial (b) Date thereof 10/8/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) OCT 7 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) (Signature)

VS 150

Correct age is especially important. Typewrite or print plainly in ink.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6, 1947, at 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1, 1947 to Oct 6 1947, and that I last saw him alive on Oct 5 1947.

Immediate cause of death Carcinoma of Lt. Lung. — Duration ?

Due to

Due to

Other Conditions Hypertension and Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Tankey M. D.

Address 441 S. Kelwood Av Date signed 10/7/47

5783 LW 105666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 1/a

G55783 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 804 Reservoir (If rural, give location)
(e) Citizen of foreign country? Ono (Yes or No)
If yes, name country

3 (a) FULL NAME
Mabel Fitzpatrick

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widowed

6 (b) Name of husband or wife Edward J. Fitzpatrick
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Sept. 6-1875

8. AGE: Years	Months	Days	If less than one day
72	0	29	###### min.

9. Birthplace Penna. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Coffin
13. Birthplace Penna.

MOTHER
14. Maiden Name Susan Knause
15. Birthplace Penna.

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 10/8/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Immanuel Cemetery
Location 2809 Grindon Avenue, Balto. Md

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) OCT 8 1947 (b)
(Date received by registrar)

Funeral Director

VS 150 . . . A

Correct age is especially important

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 5 1947, at 8:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 29 1946 to Oct. 5 1947, and that I last saw her alive on Oct. 5 1947.

Immediate cause of death Hypertensive Arteriosclerotic C.V. Disease & Decompensation — Duration

Due to

Due to

Other Conditions Hypertensive

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Cn above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert A. Fowler M. D.
Address Balto City Hosp. Date signed 10-6-47

927

55784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G55784

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1523 N. Bond Street
(c) Hospital or institution: 8

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1523 N. Bond Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie V. Owen

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Clarence P. Owen
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) July 19, 1890

8. AGE: Years	Months	Days	If less than one day
57	2	17	###### hrs. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Patrick Rigney
13. Birthplace Ireland

MOTHER
14. Maiden Name Jennette Huttenberger
15. Birthplace Baltimore, Md.

16 (a) Informant Francis C. Owen (Son)
(b) Address 1523 N. Bond Street

17 (a) Burial (b) Date thereof 10/10/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oaklawn Cemetery
Location Eastern Avenue, Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) OCT 7 1947 (Date rec'd by registrar) (b) [signature] Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6, 1947, at ..... M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1947 to Oct 6 1947 and that I last saw her alive on Oct 5 1947

Immediate cause of death Cerebral hemorrhage — Duration 7 days
Due to Hypertension — 2
Due to .....
Other Conditions .....
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature [signature] M. D.
Address 2607 Fairfield Date signed 10-7-47

X

5785

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G55785

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 101 S. ANN ST
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 101 S. ANN ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KATHERINE KOGUT

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6 (b) Name of husband or wife FRANK KOGUT
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace POLAND (Town, county, and state)
10. Usual Occupation HOUSE WORK AT HOME
11. Industry or business

FATHER
12. Name Rys
13. Birthplace POLAND

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace POLAND

16 (a) Informant MRS. A. MILLER
(b) Address 101 S. ANN ST.

17 (a) BURIAL (b) Date thereof Oct 9 /47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ST. STANISLAUS
Location BALTIMORE

18 (a) Funeral director Fred W. Ozarowski
(b) Address 1930 Eastern Ave.

19 (c) Oct 7 1947 (b) Huntington Williams M.D.
Date rec'd by registrar (Signature of Registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 5 1947, at 9P M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept. 1943 to Oct 5, 1947, and that I last saw h[illegible] alive on Oct 5, 1947.

Immediate cause of death
Hypocorchound
Puperbol
Due to Cerebral Arterio
Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
years
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 708 Y. Fait Ave. Date signed 10/6/47

5786 BC# G 38944

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓14

Registered No. 25286

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edwood & Greene Sts
(c) Hospital or institution:
University Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1042 W. Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PHYLLIS A CRONISE

3 (b) If veteran, name war	3 (c) Social Security Account No.
✓	✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 2, 1946

8. AGE: Years	Months	Days	If less than one day
1	9	4	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Stanley C. Cronise
13. Birthplace Maryland

MOTHER
14. Maiden Name Genevieve A. Kelly
15. Birthplace Maryland

16 (a) Informant Mr Stanley C. Cronise
(b) Address 1042 W Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Road

18 (a) Funeral director John Conway & Son
(b) Address 1200 Edmondson Ave

19 (a) 7 1947 (Date rec'd by registrar) (b) Arthur Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 1947, at 12:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-29 1947, to 10-6 1947, and that I last saw her alive on 10-6 1947.

Immediate cause of death	Duration
Tuberculous meningitis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. A. Oppenheimer M. D.
Address University Hosp Date signed 10-6-47

correct age in carefully improvise

G55787 1944 B-70304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered No. G55787

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 6
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 119 N. Durham St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country.....

3 (a) FULL NAME Adeline Finn

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 2/1/47

8. AGE: Years	Months	Days	If less than one day
	8	5	..... hr. ..... min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name Charles Finn
13. Birthplace Md

MOTHER
14. Maiden Name Doris Cavalier
15. Birthplace Md

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 10/9/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location W. Fredrick Rd.
18 (a) Funeral director H. W. E. Dippel's Sons
(b) Address Lombard & Ann Sts.
19 (a) 7 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6 1947, at 6 P. M
21. I certify that death occurred on the date above stated; that I attended deceased from 8/30 1947 to 10/6 1947, and that I last saw her alive on 10/6 1947.

Immediate cause of death	Duration
Cardiac failure	
Due to ? Congenital heart disease	
Due to	
Other Conditions Hypertension Large heart + liver (Include pregnancy within 3 months of death)	

Date of operation.....
Major findings of operation:.....
.....
of autopsy.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature Lee Weil Bass
Address Johns Hopkins Hosp. Date signed M. 10 D. 6 47

X

G55788 BALTIMORE CITY HEALTH DEPARTMENT G55788

CERTIFICATE OF DEATH ✓94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3206 Fairfield Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3206 Fairfield Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Perry B. FREEMAN

3 (b) If veteran, name war —

3 (c) Social Security Account No. 247-05-3124

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife Bertha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1886

8. AGE: Years	Months	Days	If less than one day
60	10		hr. min.

9. Birthplace Georgia
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name [illegible]

13. Birthplace Macon Ga.

MOTHER 14. Maiden Name Irving

15. Birthplace Ga

16 (a) Informant Bertha Freeman

(b) Address 3206 Fairfield Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-7-1947 (month) (day) (year)

(c) Cemetery or crematory Fort Valley

Location Georgia

18 (a) Funeral director Robert E. Williams

(b) Address 1515 McCulloh St

19 (a) [illegible] (State registrar) Wellington Williams M.D.

CT [illegible]

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2, 1947, at 2 05 P.M.

21. I certify that I took charge of the remains described above, held an Insp. and Inqu. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Artery Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 10/2/47

X

G55789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G55789 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 N. Carey
(c) Hospital or institution:
Good Samaritan Home 43
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1845 S. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary M. Miller

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	W.

6 (b) Name of husband or wife Harry Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 21-1866

8. AGE: Years	Months	Days	If less than one day
80	10	14	hr. min.

9. Birthplace West Virginia (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Bart. Thomas
13. Birthplace West Virginia

MOTHER
14. Maiden Name Theresa Engle
15. Birthplace Europe

16 (a) Informant George W. Miller
(b) Address 4 W. Clement St

17 (a) Burial (b) Date thereof 10-9-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A. A. Co. Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 (a) Date received by registrar Pettington for Williams, Registrar

CT 1 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/5 1947, at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 1947 to 10/5 1947, and that I last saw her alive on 10/5 1947.

Immediate cause of death Cerebral Hemorrhage — Duration 3 hrs.
Due to Cerebroclerotic
Due to Heart Disease
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Vincent M. Treanor M. D.
Address 1703 S. Charles St Date signed 10/6/47

X

G55790

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

G55790
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1326-Pennsylvania Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1326 Pennsylvania Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VIOLA BOSSIEUX BEALE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years	Months	Days	If less than one day
44			hr. min.

9. Birthplace Richmond, Va.
(Town, county, and state)
Housewife.

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Bessie Smith
15. Birthplace Va.

16 (a) Informant William F. Beale
(b) Address 1326- Pennsylvania Ave.

17 (a) Burial (b) Date thereof 10-10-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna. Ave.

19 (a) Oct 10 1947 (b) [illegible] for Williams, M.D.
(Date received for registration) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6, 1947, at 2.30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hemorrhage of brain (cerebral)
Edema of lungs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George F. Merrill M.D.
Medical Examiner.
Date signed 10-6-47

G55791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

G55791 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2629 Edmondson Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2629 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LAURA CATHERINE LEARY

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widow

6 (b) Name of husband or wife Jacob Leary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16, 1859

8. AGE: Years	Months	Days	If less than one day
88	2	20	hr. min.

9. Birthplace Frederick, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Lambright
13. Birthplace Frederick Co., Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Mary D. Kaupp
(b) Address 2622 Edmondson Ave.

17 (a) Burial (b) Date thereof 10/9/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 10-7 1947 Huntington Williams, M.D. Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/6 1947 at 10.25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1947 to Oct 6 1947 and that I last saw h[illegible] alive on 10/4 1947

Immediate cause of death	Duration
Carcinoma of Esophagus	3 Months
Due to	
Due to	
Other Conditions Cardio-Vascular Disease & Hypertension (Include pregnancy within 3 months of death)	10 Years

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Eliot W. Johnson M. D.
Address 3432 Frederick Ave. Date signed

V S 150

655792

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

130

655792

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) 24 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County York
(c) City or town Woodbine
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** ~~Mrs Clifford E Wright (Ethel)~~ Mrs. Ethel Wright

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Clifford E Wright
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 11/10/1894

8. AGE: Years	Months	Days	If less than one day
52	10	27	..... hr. ..... min.

9. Birthplace Pennsylvania
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Hugh Barton
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Electra Pantree
15. Birthplace Pennsylvania

16 (a) Informant Mr. Clifford E Wright
(b) Address Woodbine, Pa.

17 (a) ..... (b) Date thereof .....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Rose
Location York, Penna.
18 (a) Funeral director Wm. J. Fisher & Son
(b) Address Market & Penn Aves.
19 (a) ..... (b) .....
(Signature of registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7 1947, at 4 05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 13 1947, to October 7 1947, and that I last saw her alive on October 7 1947.

Immediate cause of death
Miliary tuberculosis

Duration
3 & [illegible] mos.
over

Due to .....
Due to .....
Other Conditions .....
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....
23. Signature H. R. Freeman Jr. M.D.
Address Union Memorial Hosp. Date signed 10/7/47

Correct age is especially important if deceased is under one year or over 65.

G55793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G55793 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3616 Park Heights Ave.
(c) Hospital or institution:

15 17

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3616 Park Heights Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE D. SPICER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Rose L. Spicer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1859

8. AGE: Years 88 | Months 0 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore, ~~BALTIMORE~~ Maryland,
(Town, county, and state)

10. Usual Occupation Insurance Agent,

11. Industry or business Life Ins.

FATHER
12. Name George Washington Spicer,
13. Birthplace Maryland,

MOTHER
14. Maiden Name Elizabeth Kindig,
15. Birthplace Maryland.

16 (a) Informant Mrs. Rose L. Spicer,
(b) Address 3616 Park Heights Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore City,

18 (a) Funeral director C. Vernon Lemmon.
(b) Address 4611 Park Heights Ave.
Embalmer for Baltimore, Md.

19 (a) OCT 7 1947 (Date rec'd by registrar) (b) 8 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6, 1947, at 5.30 AM

21. I certify that I took charge of the remains described above, held an autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature George L. Merrill M.D.
Medical Examiner.
Date signed 10-6-47

VS 151

G55794 G55794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division
(c) Hospital or institution:
Provident 17

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1347 Myrtle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Hairston

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Fe | 5. Color or race N | 6 (a) Single, married, widowed, or divorced W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-11-1913

8. AGE: Years 44 | Months 8 | Days 26 | If less than one day hr. min.

9. Birthplace Lexington, N. C.
(Town, county and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER 12. Name Sum Hairston
13. Birthplace N. C.

MOTHER 14. Maiden Name Alice ?
15. Birthplace N. C.

16 (a) Informant Adell Hairston
(b) Address 1347 myrtle ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 9, 1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Cem.
Location Arbutus Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley ave

19 (a) [illegible] (Date rec'd by registrar) Huntington Williams, M.D.

Correct age if especially important

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/6 1947, at 3:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/13 1947 to 10/6 1947 and that I last saw h[illegible] alive on 10/6 1947.

Immediate cause of death Uremia — Duration

Due to Hypertension, Cardiac Vascular-Renal Disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Preston Hunt M. D.
Address 1514 Division Date signed 10/7/47

VS 150

G55795

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V/86a

G55795 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home & Hospital 6 W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 717 N. Luzerne Ave.
(If rural give location)
(e) Citizen of foreign country? U.S. (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Florence Beatty

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Mr. Wm. T. Beatty
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20, 1876

8. AGE: Years	Months	Days	If less than one day
71	7	16	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Florence Slattery
13. Birthplace Ireland.

MOTHER
14. Maiden Name Annie Scanlon
15. Birthplace Ireland.

16 (a) Informant Mrs. Florence Beatty
(b) Address 717 N. Luzerne Ave.

17 (a) Burial (b) Date thereof 10/9/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Rd.

18 (a) Funeral director John J. McGan
(b) Address 800 E. Balto. St.

19 (a) [illegible] (b) [illegible] Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/5/47 1947, at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/29/47 19 to 10/5/47 19, and that I last saw him alive on 10/5/47 19

Immediate cause of death	Duration
Terminal aspiration pneumonia	
Due to Arteriosclerotic Cardiovascular disease (congenital deformity)	
Other Conditions Multiple rib fractures	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Terminal aspiration pneumonia

FOR PHYSICIAN
Underline the cause to which death should be charged statis-

22. If death was due to external causes, fill in the following: 6/2
(a) Accident, suicide, or homicide Fall
(b) Date of occurrence 8/29/47 7 P.M.
(c) Where did injury occur? 717 N. Luzerne (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Fell down stairs.

23. Signature Joseph D. Antonio M.D.
Address Church Home & Hosp. Date signed 10/5/47
For B. J. R. Davis by Howard J. Mendelsohn, M.D.

G55796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G55796 Registered No. 122B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~1313 W Fayette St~~
(c) Hospital or institution:
Univ. of Maryland Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County N. 96.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Leakville
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howell, Eldee

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Edith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1915

8. AGE: Years	Months	Days	If less than one day
32			hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business

FATHER
12. Name Walter B Howell
13. Birthplace Va.

MOTHER
14. Maiden Name Pocahontas Light
15. Birthplace Va.

16 (a) Informant Leakesville Shop Friend
(b) Address Leakesville NC

17 (a) Funeral (Burial, cremation, or removal) (b) Date thereof 10/7/47 (month) (day) (year)
(c) Cemetery or crematory Leakesville
Location Leakesville NC

18 (a) Funeral director Wilson & Pope
(b) Address 317 E Front

19 (a) [illegible] (Date received by registrar) Washington Williamsburg

OCT 1950

VS 150

Correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7 1947 at 2:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1 1947 to 10/7 1947, and that I last saw him alive on 10/7 1947.

Immediate cause of death	Duration
Respiratory Collapse	
Due to Massive Atelectasis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 10/1/47
Major findings of operation: Intestinal Obstruction, Adhesions
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H N Taylor M. D.
Address Edenton & Broome Sts Date signed 10/7

X

Dr. 65797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

65797 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2920 Northern Parkway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2920 Northern Parkway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Conrad Peter Protzman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Johanna Protzman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27, 1871

8. AGE: Years	Months	Days	If less than one day
76	3	9	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Cabinet Maker
11. Industry or business

FATHER
12. Name William Protzman
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina Schnee
15. Birthplace Germany

16 (a) Informant Mrs. Johanna Protzman
(b) Address 2920 Northern Parkway

17 (a) Burial (b) Date thereof 10-9-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore, Md.

16 (a) Funeral director Leonard J. Ruca
(b) Address [illegible] Road, 14

19 (a) (Date rec'd by registrar) (b)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-6- 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1947 to 10/6 1947 and that I last saw h alive on 10/6 1947

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 503 Hartford Rd Date signed 10/7/47

G55798 — BALTIMORE CITY HEALTH DEPARTMENT — G55798

CERTIFICATE OF DEATH 48a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1731 N. Carey St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1731 N. Carey St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Sheppard

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	married

6 (b) Name of husband or wife Harvey Sheppard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 27, 1904

8. AGE: Years	Months	Days	If less than one day
43	5	7	hr. min.

9. Birthplace Va
(Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Richard Harrison
13. Birthplace Va

MOTHER
14. Maiden Name alice ?
15. Birthplace Va

16 (a) Informant Harvey R. Sheppard
(b) Address 1731 N. Carey St

17 (a) Buried (b) Date thereof 10-8-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location md

18 (a) Funeral director George E. Kelsen
(b) Address 1303 Presstman St

19 (a) Filed (b) [illegible]
Date filed by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4 1947, at 11:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 19 47 to Oct 4 19 47
and that I last saw h[illegible] alive on Oct 4 19 47

Immediate cause of death	Duration
Carcinoma (Cervix)	
Due to Uremia	7
Due to	2m
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. J. Halpern M. D.
Address 1 W 85 St Date signed 10/7/47

VS 150

G55799 BALTIMORE CITY HEALTH DEPARTMENT G55799

CERTIFICATE OF DEATH 1318

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d. 9 h.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 907 Pierce St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Burdina Adams

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	married

6 (b) Name of husband or wife Russell Adams.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 14, 1914

8. AGE: Years	Months	Days	If less than one day
32	9	20	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name James P. Courtney
13. Birthplace Cambridge, Md.

MOTHER
14. Maiden Name Edna B. Johnson
15. Birthplace Cambridge, Md.

16 (a) Informant Mrs. Joseph Simpson (Cousin)
(b) Address 907 Pierce Ste

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 9 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) Filed Oct 1947 (Date registered) Worthington Williams, M.D. Registrar

OCT

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3, 1947, at 7 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic glomerular nephritis

Due to

Other Conditions Congestion and edema of lungs
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L. Royer M.D. Medical Examiner.
Date signed 10-6-47

X

G55800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G55800 Registered No.

170c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel Co.
(c) City or town Glen Burnie
(If outside city or town limits, write RURAL and give town)
(d) Street No. 8th Ave. & Crain Highway, N.W.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN LEONARD SAMM

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1930

8. AGE: Years 16 | Months 11 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Student - High school

11. Industry or business

FATHER
12. Name John C. Samm
13. Birthplace Baltimore

MOTHER
14. Maiden Name Amelia C. Hoffnagle
15. Birthplace Baltimore

16 (a) Informant John C. Samm
(b) Address 8th Ave. & Crain Highway, Glen Burnie, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 9, 47 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Md.

18 (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie, Md.

19 (a) 1947 (b) Received by registrar Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6, 1947, at 1.40 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Traumatic peritonitis

Due to Perforation of Ileum

Other Conditions Fracture Left Tibia + Fibula Infection Phlegmon Pelvis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: a.a.co.
(a) Date of injury 10-1-47 at 8.30 p. M.
(b) Where did injury occur? Stoney Creek Road.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Operator - auto scooter collided with auto

23. Signature Carl L. Young M.D.
Medical Examiner.
Date signed 10-6-47

G55801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G55801 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5029 Wetheredsville Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5029 Wetheredsville Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PATRICK F. DOYLE

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widower

6 (b) Name of husband or wife Jennie E. Doyle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1856

8. AGE: Years	Months	Days	If less than one day
91	7	6	hr. min.

9. Birthplace Dickeyville, Md.
(Town, county, and state)
10. Usual Occupation Retired Textile Mfgr.
11. Industry or business

FATHER
12. Name Doyle
13. Birthplace Ireland

MOTHER
14. Maiden Name -
15. Birthplace Ireland

16 (a) Informant Mr. J. Carroll Doyle
(b) Address 310 American Bldg., Balto. 2

17 (a) Burial (b) Date thereof 10/8/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

OCT 6 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4, 1947, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7 1947, to Oct 4 1947, and that I last saw h[illegible] alive on Oct 4 1947.

Immediate cause of death	Duration
Acute Pulmonary Edema	10 days
Due to Arteriosclerosis	10 years
Due to Myocardial	2 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. E. Bennett M. D.
Address 4379 Eastern Date signed Oct 8

correct age is especially important. Physicians please

X

55802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

Registered No. 55802

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd St
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County
(c) City or town Stephen City
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Carroll Stephen Ebersole

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	child

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 14, 1946

8. AGE: Years	Months	Days	If less than one day
	5	29	hr. min.

9. Birthplace Virginia (Stephen City ?)
(Town, county, and state)

10. Usual Occupation child

11. Industry or business

MOTHER | FATHER

12. Name Richard V Ebersole

13. Birthplace Virginia

14. Maiden Name Dale Keckney

15. Birthplace West Virginia

16 (a) Informant Mother

(b) Address Stephen City, Virginia

17 (a) Removal (b) Date thereof June 14, 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory R. Frederick
Location Stephen City, Virginia

18 (a) Funeral director Wayne B. Omps

(b) Address Winchester, Virginia

DEC 7 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1947, at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1947 to June 12 1947, and that I last saw him alive on June 12 1947.

	Duration
Immediate cause of death Brain damage (coma) due	
Due to aspiration	1 month
Due to debilitated state caused by Diarrhea	
Other Conditions Infection in Gutract	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Katherine Sprunt M. D.
Address Union Mem. Hosp. Date signed 6-12-47

VS 150

CORRECT AGE IS expecting [illegible]

5803

A57990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X G55803 Registered No. 54a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address —
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Allegany
(c) City or town Cumberland.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 419 Columbia, St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul Joseph Billing

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-23-44

8. AGE: Years	Months	Days	If less than one day
3	1	11	hr. min.

9. Birthplace Md. - Cumberland
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name George C. Billing
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Williams
15. Birthplace Md.

16 (a) Informant Record
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) burial (b) Date thereof Oct 7 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Peter & Paul Cemetery
Location Cumberland, Md

18 (a) Funeral director Louis Stein, Inc.
(b) Address Cumberland Md.

OCT 7 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct- 4- 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-30- 1947 to 10-4- 1947 and that I last saw him alive on 10-4- 1947

Immediate cause of death: Glioma of Optic Chiasm + 3rd ventricle — Duration: 3 mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation Oct 3 47
Major findings of operation: Third Ventricle tumor.
of autopsy: Chiasm Glioma

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George A Culbreth
Address Johns Hopkins Hosp. Date signed 4 Oct, 47

X

804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √ 55E

Registered No. G55804

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Somerset
(c) City or town Deals Island
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Campbell Abbott

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Wid.

6 (b) Name of husband or wife Virgie Webster
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1875

8. AGE: Years	Months	Days	If less than one day
72	3	13	hr. min.

9. Birthplace Deals Island, Md.
(Town, county, and state)
10. Usual Occupation Cook
11. Industry or business Merchant Seaman

FATHER
12. Name Wentley Abbott
13. Birthplace Deals Island, Md.

MOTHER
14. Maiden Name Virginia Jones
15. Birthplace Deals Island, Md.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (b) Date thereof Aug 27-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Peters M E
Location Deals Island Md
18 (a) Funeral director H Wheeler
(b) Address Deals Island Md.
19 (a) Aug 28 (b) [illegible]
(Date rec'd by Registrar) (Registrar)
OCT 1 1947
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 25 1947, at 8:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 14 1947 to Aug. 25 1947 and that I last saw him alive on Aug. 25 1947.

	Duration
Immediate cause of death Mucosal and submucosal hemorrhage	3 wks.
Due to Lymphosarcoma of lymph nodes generalized	2 yrs. & 4 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rheim M. Jones
Rheim M. Jones, SA Surgeon
Address US Marine Hospital Date signed 8/26/47

G55805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G55805 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 207 W. Preston St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits write RURAL and give town)
(d) Street No. 207 W. Preston St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Betty Clark

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3, 1892

8. AGE: Years	Months	Days	If less than one day
56	5	1	hr. min.

9. Birthplace Chatman, Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles Clark
13. Birthplace Chatman Va.

MOTHER
14. Maiden Name Bettye Clark
15. Birthplace Chatman Va.

16 (a) Informant James Clark
(b) Address 207 W. Hoffman St.

17 (a) (Burial, cremation, or removal) (b) Date thereof Oct 7 47
(month) (day) (year)
(c) Cemetery or crematory Danville, Va.
Location

18 (a) Funeral director A. Halstead Undertaking Co.
(b) Address 9 E. Franklin St.

Oct 7 1947
(Date rec'd by registrar) (Signature of Registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-4 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-19 1947, to 10-4 1947, and that I last saw h[illegible] alive on 10-3 1947

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Arteriosclerosis	1 yr.
Due to	
Other Conditions Arthritis	6 mos.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Atwell Jones M. D.
Address 554 Adolphus St. Date signed 10-7-47

G55806

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 H

G55806

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ohio (b) County
(c) City or town Steubenville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 842 N. 4th St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph B. McCullough

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Helen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-18-90

8. AGE: Years	Months	Days	If less than one day
57	4	19	hr. min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation Real Estate

11. Industry or business

FATHER
12. Name Dr McCullough Jr
13. Birthplace Ohio

MOTHER
14. Maiden Name Mary Beatty
15. Birthplace Ohio

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 9/47 (month) (day) (year)
(c) Cemetery or crematory Union Cemetery
Location Steubenville, Ohio

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eastern Place

19 (a) [illegible] (Date received by Registrar) [illegible] Washington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 1947, at 10 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 26 1947 to Oct 7 1947 and that I last saw him alive on Oct 7 1947

Immediate cause of death	Duration
Cardiorespiratory - failure	2 hrs
Due to Post-operative atelectasis	5 hrs
Due to Retroperitoneal sarcoma	2½ yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Oct 6, 47
Major findings of operation: Retroperitoneal Sarcoma in region of duodenum
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. J. Edgerton M. D.
Address Hopkins Hospital Date signed Oct 7

5807

BC# G 90844

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

160a

Registered No. G55807

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 1 day
(e) Length of stay in Baltimore (yrs., mos., or days): 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: Baltimore
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 3801 Northern Pkway (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: Richard Thomas Montague, Jr.

3 (b) If veteran, name war:
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife:
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Oct 6, 1947
8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.
9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: None
11. Industry or business:

FATHER
12. Name: Richard T. Montague Jr.
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Josephine A. Stafford
15. Birthplace: Wilkes-Barre, Pa.

16 (a) Informant: Josephine A. Montague
(b) Address: 3801 Northern Pkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10/8/47 (month) (day) (year)
(c) Cemetery or crematory: Parkwood
Location: Taylor Ave.

18 (a) Funeral director: Sansbury Funeral Home
(b) Address: 2401 Gilsey Rd.

OCT 8 1947 (Date rec'd by registrar) (b) Huntington Williams, Md.

VS 150

Correct age if expressing in months, days, or hours.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 7, 1947, at 10:02 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 6, 1947 to Oct. 7, 1947, and that I last saw h. alive on Oct. 7, 1947.

	Duration
Immediate cause of death: Respiratory Failure	
Due to: Bronchopneumonia Rt. Lower Lobe	
Due to: Aspiration	
Other Conditions: Cerebral Hemorrhage (Include pregnancy within 3 months of death)	

Date of operation: None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Anthony F. DiPaula M.D.
Address: St. Joseph's Hosp. Date signed: 10/7/47

107

5808 G55808

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

Registered No.

1. PLACE OF DEATH: 654 Haw St.
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 654 Haw St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen Sutton Sutton

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown —

8. AGE: Years 57 | Months — | Days — | If less than one day hr. min.

9. Birthplace Maryland ?
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name John Adams.
13. Birthplace Unknown —

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown —

16 (a) Informant Mrs Annie Black.
(b) Address 654 Haw St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 47 (month) (day) (year)
(c) Cemetery or crematory Mt Zion Cemtry
Location Balto

18 (a) Funeral director Walter R. Longer
(b) Address 134 W Hamburg St

(Date received) (Registrar) Huntington Williams M.D.

correct age is especially important.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4 1947 at M

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 26 1947 to Feb 4 1947 and that I last saw him alive on Feb 3 1947

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Paralysis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ben Rhett M.D.

Address 734 E Pratt Date signed Feb 5 1947

5809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G55809

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3508 FOREST PARK AVE
(c) Hospital or institution:
15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 52 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3508 FOREST PARK AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL M. CHARLOW

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife MOLLIE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB 27, 1891

8. AGE: Years	Months	Days	If less than one day
56	7	9	hr. min.

9. Birthplace RUSSIA
(Town, county, and state)
10. Usual Occupation CLOTHING MERCHANT
11. Industry or business

FATHER
12. Name JACOB
13. Birthplace RUSSIA

MOTHER
14. Maiden Name MINNIE
15. Birthplace RUSSIA

16 (a) Informant WIFE
(b) Address

17 (a) BURIAL (b) Date thereof 10-8-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory WASH. BLVD
Location WASH BLVD

18 (a) Funeral director VOCK LEWIS INC
(b) Address 2100 EUTAW PLACE

19 (a) 8 1947 (b) Huntington Williams M.D.
(Date received by registrar)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 6 1947, at 8 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1947 to 10-6 1947, and that I last saw h~~im~~ alive on 10-6 1947

Immediate cause of death
Carcinoma of Colon with metastases
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation Aug. 1947
Major findings of operation: Carcinoma of Intestines
of autopsy:

Duration
~~3 mos~~ 6 mos.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sol Smith M.D.
Address 1223 E. North Ave Date signed Oct 7, 1947

5810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1462

Registered No. C55810

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5716 Jouguel Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Lifeg

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5716 Jouguel Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth Randall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bernard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1920

8. AGE: Years 27 | Months | Days | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name David Lipsitz
13. Birthplace Russia

MOTHER
14. Maiden Name Esther
15. Birthplace Russia

16 (a) Informant Bernard Randall
(b) Address 5716 Jouguel Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-8-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia & Hamilton Ave

18 (a) Funeral director Black Levin Inc.
(b) Address 2160 Eutaw Place

19 OCT 8 1947 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

V S 150

Correct age is especially important

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-7-1947 at 01 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/5 1947, to 10/7 1947, and that I last saw her alive on 10/7 1947.

Immediate cause of death: Carcinoma of stomach — Duration: 7 mos

Due to: with peritoneal metastasis

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation 3/25/47

Major findings of operation: carcinoma of stomach

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H A Zuntzing M. D.
Address 2300 Eutaw Pl Date signed 10/8/47

X

5811 4348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 153

Registered No. C55811

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1506 Pressen Ch.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Nickerson.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Married

6 (b) Name of husband or wife Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-10-11

8. AGE: Years	Months	Days	If less than one day
35	9	24	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business ?

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Emma Nickerson
15. Birthplace Va. - Friends.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Oct 9-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Chester Md.

18 (a) Funeral director Sewell & Henry
(b) Address Cambridge Md.

19 (a) OCT 8 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4, 1947 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 15 1947 to Oct. 5 1947 and that I last saw h. him alive on Oct. 5 1947.

Immediate cause of death	Duration
Respiratory failure	
Due to Pneumonitis	
Due to Probably Lupus erythematosus disease.	
Other Conditions Psoriasis	

(Include pregnancy within 3 months of death)
Date of operation Biopsy, 2 times
Major findings of operation: Nodes + skin Sept 13 & Sept 20 - psoriasis
of autopsy: Brain (Pneumonia)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Victor A. McKusick M.D.
Address Johns Hopkins Hosp. Date signed 10/6

X

5812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓937

G55812 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1206½ McCulloh
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write R.F.D. and give town)
(d) Street No. 1206½ McCulloh (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Riddick (Brown)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1877

8. AGE: Years	Months	Days	If less than one day
70	8	3	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name George Tyler
13. Birthplace Md.

MOTHER
14. Maiden Name Amanda Wallace
15. Birthplace Md.

16 (a) Informant Bertha Brown
(b) Address 1206½ McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-8-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location Cedar Hill, Md.

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Whitehill Ave.

OCT (a) 8 1947 (Date rec'd by registrar) Huntington Williams, M.D.

correct age is especially important. Physicians, please

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5 1947 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29 1947 to Oct 5 1947 and that I last saw h[illegible] alive on Oct 5 1947

Immediate cause of death: (a) Myocardial Insufficiency Duration: 2 days
Due to: (b) Hypertension Heart Disease 1 year
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature H. Williams
Address 75 W. Lanvale Date signed Oct 7 1947

5813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

Registered No. G55813

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4506 Sorrento Rd
(c) Hospital or institution: Colonial Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) Twelve
(e) Length of stay in Baltimore (yrs., mos., or days) Twelve

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Halethorpe Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4620 Washington Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob J. Kirchhoefer

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Rose Dehner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
76			hr. min.

9. Birthplace Halethorpe Md.
(Town, county, and state)
10. Usual Occupation Farmer, Retired
11. Industry or business Self

FATHER
12. Name August Kirchhoefer
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Schantz
15. Birthplace Germany.

16 (a) Informant Mrs. Potter
(b) Address 4640 Washington Rd.

17 (a) Burial (b) Date thereof 10/10/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location 4300 Old Frederick Rd

18 (a) Funeral director John J. Coyne & Son
(b) Address 901-07 Hollins St

19 (a) OCT 8 1947 (b) Name of registrar Huntington Williams M.D.
(Date of registration)

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7th 1947, at 6:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 10 1947 to Oct. 6 1947 and that I last saw h[illegible] alive on Oct. 6 1947

Immediate cause of death	Duration
Acute Cardiac Failure	2 Hrs
Due to Coronary Thrombosis	unknown
Due to Coronary Occluded Vessel	unknown
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William L. Fearn M.D.
Address 3025 Belair Rd. Date signed Oct 7-47

5814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C55814

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) less than 12 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1007 Riverside Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Carroll Grayson Headley

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Madeline Floyd Headley
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) July 13, 1897

8. AGE: Years	Months	Days	If less than one day
50	2	25	....hr. ....min.

9. Birthplace Burgess Store, Va.
(Town, county, and state)
10. Usual Occupation Chief Engineer
11. Industry or business Seafarer

FATHER
12. Name Luther Headley
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Elizabeth Doulin
15. Birthplace Va.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (b) Date thereof 10/9/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Taylor Ave.

18 (a) Funeral director John F. Henny Inc.
(b) Address 711 Light St.

19 (a) OCT 8 1947 (b) [illegible]
Rec'd by registrar

V S 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Oct. 6 1947, at 11:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 6 1947, to Oct. 6 1947, and that I last saw him alive on Oct. 6 1947.

Immediate cause of death	Duration
Cardiac insufficiency	UNKNOWN
Due to Arteriosclerotic heart disease	UNKNOWN
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon
Address Clinical Director Date signed 10/6/47

5815

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

Registered No. G55815

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baton Ave
(c) Hospital or institution: St Agnes Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 32 Talbott St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY B. MATTINGLY

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife James

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 30, 1881

8. AGE: Years	Months	Days	If less than one day
65	11	6	..... hr. ..... min.

9. Birthplace Maryland.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Albert Tarleton
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Mary Elliott
15. Birthplace Maryland.

16 (a) Informant Mrs McDevitt Bayne
(b) Address 32 Talbott St.

17 (a) Burial (b) Date thereof 10/8/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd.

18 (a) Funeral director John F Denny Inc
(b) Address 716 Light St.

19 (a) Oct 8 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5 1947 at 11:57 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 28 1947 to Oct 5 1947 and that I last saw her alive on Oct 5 1947.

Immediate cause of death	Duration
Cardiac Failure	
Due to Coronary Occlusion	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James E Hamilton M.D.

Address 1 Elgin Terrace Date signed Oct 5, 47

× Oct 5, 47

5816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124a

G55816
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green & Redwood Sts.
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 0 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Halethorpe
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1716 Carroll Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles W. Lowman (Charles W. Lowman)

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-01-4862

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ethel Lee Lowman

6 (c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): Aug. 11, 1906

8. AGE: Years: 41 | Months: 1 | Days: 22 | If less than one day: hr. min.

9. Birthplace: Elkridge Maryland
(Town, county, and state)

10. Usual Occupation: Barber & Mechanic

11. Industry or business: Hecht Bros. Ware House

FATHER
12. Name: Harry E. Lowman
13. Birthplace: Maryland

MOTHER
14. Maiden Name:
15. Birthplace: Maryland

16 (a) Informant: Mrs. Ethel L. Lowman
(b) Address: 1716 Carroll Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof OCT. 7/47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore, Maryland

18 (a) Funeral director: F.B. WIPPERT & SON
(b) Address: 1300 EUTAW PLACE

19 (a) OCT 8 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3rd 1947, at 3 45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Acute pancreatitis

Due to: Fatty degeneration of liver

Due to: Myocardial degeneration

Other Conditions: NONE

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: George G. Merrill M.D.
Medical Examiner.

Date signed 10-4-47

5817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √61

Registered No. C55817

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 Stony Run Lane
(c) Hospital or institution: HillCrest
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 204 Kimble Road
Kemble (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME MARY E. GEIPE

3 (b) If veteran, name war: **********
3 (c) Social Security Account No. **********

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Millard F. Geipe
6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr.) 4 / 24 /1865

8. AGE: Years	Months	Days	If less than one day
82	5	10	********** hr. ********** min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name George Koenig
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Jerome DePaula
(b) Address 204 Kimble Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 8/47 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore Maryland

18 (a) Funeral director F. B. WIPPERT & SON
(b) Address 1300 EUTAW PLACE.

19 (a) OCT 8 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

Correct age if necessary when space is provided.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 4th. 19 47 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1- 1947 to 10-4 1947 and that I last saw h er alive on 10-4 1947

Immediate cause of death	Duration
cerebral Hemorrhage -	4 days
Due to Arterio Sclerosis - & Diabetis -	years ?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. Durand M.D.
Address Medical Arts Bldg Date signed 10-6-47

818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124 B

Registered No. C55818

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3819 Cranston Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oscar (CHARLES) J. BIEDENKAPP

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-05-0538

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Agnes

6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr.) May 5th. 1904

8. AGE: Years	Months	Days	If less than one day
43	5	2	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation PBX. Instructor
11. Industry or business C & P T.Co.

FATHER
12. Name John Biedenkapp
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Fuch
15. Birthplace Germany

16 (a) Informant Mrs. Katherine Biedenkapp
(b) Address 2715 West Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 9/47 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore Maryland

18 (a) Funeral director F.B.WIPPERT & SON
(b) Address 1300 Eutaw Place 17

19 OCT 8 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7, 1947 at 8.10p M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Fatty Degeneration of Liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Carl L. Reyer M.D.
Medical Examiner

Date signed 10-7-47

5819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V. 13 P

Registered No. C55819

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 738-Waesche St
(c) Hospital or institution: 4

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give county)
(d) Street No. 738-Waesche St.
(If rural give location)
(e) Citizen of foreign country? ... (Yes or No)
If yes, name country ...

3 (a) FULL NAME George Washington

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Col	married

6 (b) Name of husband or wife Clara
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Oct. 27 1879

8. AGE: Years	Months	Days	If less than one day
67	11	10	... hr. ... min.

9. Birthplace N. C.
(Town, county, and state)
10. Usual Occupation Barber
11. Industry or business —

FATHER
12. Name John Washington
13. Birthplace N. C.

MOTHER
14. Maiden Name Jemima
15. Birthplace N. C.

16 (a) Informant Goldie Washington
(b) Address 1738-Waesche St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/10/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location —

18 (a) Funeral director A. Halstead
(b) Address 918-Druid Hill Ave

19 (a) OCT 8 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/7/ 1947, at 7:a M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 11 1947, to Oct 7 1947, and that I last saw him alive on Oct 7 1947

Immediate cause of death	Duration
Pulmonary Tuberculosis	3 mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at ... M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work? ...
(Specify type of place)
(e) Means of injury ...

23. Signature Douglas Sheppard M. D.
Address 1604 N. Fulton Ave Date signed 10/8/47

55820

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 055820

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3603 Rosedale Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3603 Rosedale Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George H. Geiger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single, married~~, widowed, or divorced: Widowed

6 (b) Name of ~~husband~~ or wife: Ella V. Geiger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 21st 1858

8. AGE: Years 88 | Months 9 | Days 16 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John Geiger
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Weaver
15. Birthplace Germany

16 (a) Informant Mrs. Alice K. Hurlock
(b) Address 3603 Rosedale Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/10/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 OCT 8 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7th 1947 19 at 4:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1944 to Oct. 7, 1947 and that I last saw h~~im~~ alive on Oct. 5, 1947

Immediate cause of death: Coronary thrombosis — Duration

Due to: Arthiosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sidney L. Levy, M.D.
Address 23 W. Eutaw Place Date signed 10/7/47

55821

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. C55821

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Johns Hopkins Hosp 7
(d) Length of stay in hospital or inst. (yrs., mos., or days) Deft.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 500 N Patterson Pk Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Caroline M. Stevens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Joseph T. Stevens

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1st 1874

8. AGE: Years 73 | Months 9 | Days 5 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Frederick Schwab
13. Birthplace Md.

MOTHER
14. Maiden Name Caroline ?
15. Birthplace Md.

16 (a) Informant Mrs. Mabel Simmons
(b) Address 105 N. Linwood Ave

17 (a) Burial (b) Date thereof 10/9/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Holy Cross
Location A. A. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul

19 (a) OCT 8 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1947, at 3:15 P M

21. I certify that I took charge of the remains described above, held an Autopsy Ext Exam thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wytham S Hubbard M.D.
Medical Examiner.
Date signed Oct 7th 1947

5822

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G55822 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) one day
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 9
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2902 London Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ralph K. Wells

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	Married

6 (b) Name of husband or wife Anna Wells.
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) June 10, 1895

8. AGE: Years	Months	Days	If less than one day
52	3	26	7 hr. 30 min.

9. Birthplace Corning, Missouri (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name Benjamin F. Wells
13. Birthplace Corning, Missouri

MOTHER
14. Maiden Name Minnie Swann
15. Birthplace Corning, Missouri

16 (a) Informant Anne Wells
(b) Address 2902 London Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/10/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) Oct 8 1947 (Date rec'd by registrar) Huntington Williams (Registrar)

correct age is especially important. Physicians, please

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7 1947, at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 6 1947 to Oct 7 1947, and that I last saw h[illegible] alive on Oct 6, 1947

Immediate cause of death	Duration
Cardiac Failure (Decompensation)	One wk.
Due to Hypertensive C.V. Disease	8 yrs.
Due to	
Other Conditions Cardiac hypertrophy & dilatation	
Prostatic adenoma (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation —
of autopsy Cardiac hypertrophy & dilatation

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph H. LiPuma M. D.
Address Mercy Hosp Date signed 10/7/47

X

55823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

G55823 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 605 N Edwards St
(c) Hospital or institution: 5

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 605 - 711 Edwards St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Archie Taylor (ARCHER TAYLOR)

3 (b) If veteran, name war Spanish A | 3 (c) Social Security Account No.

4. Sex male | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Lillie Mae

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10 1876

8. AGE: Years 71 | Months 4 | Days 25 | If less than one day hr. min.

9. Birthplace Prince Edward co Va (Town, county, and state)

10. Usual Occupation Steamboat

11. Industry or business

FATHER 12. Name Paul Armstead
13. Birthplace Va

MOTHER 14. Maiden Name unknown
15. Birthplace Va

16 (a) Informant Geneva Coles
(b) Address 605 N Edw St

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 10-9-47 (month) (day) (year)

(c) Cemetery or crematory Dulaney Valley Memory
Location Fairmount Ave. Towson

18 (a) Funeral director Wilson A. Jackson
(b) Address 916 Penna Ave

19 (c) OCT 8 1947 (Date received by registrar) Hattie Williams M.D. Registrar

Fairfield Md

correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4 1947, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-26 1947, to Oct 4 1947, and that I last saw h alive on Oct 3 1947

Immediate cause of death	Duration
(a) Mitral Insufficiency	
Due to Arterio-Sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Edward Fisher M. D.
Address 1612 E Monument Date signed 10-9-47

5824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G55824
Registered No.

1. PLACE OF DEATH: West Baltimore Hospital
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Dukeland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2518 Shirley Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Philip Posner Posner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 52 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Hersz Kelman Posner
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah Gottleib
15. Birthplace Poland

16 (a) Informant Nathan Posner
(b) Address 1921 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 8, 1947 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 OCT 8 1947 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7 1947 at 9 15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/3 1947 to 10/7 1947 and that I last saw h. alive on 10/7 1947.

Immediate cause of death Subarachnoid Hemorrhage — Duration 4 days
Due to ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature I. Goldstein M. D.
Address 1129 W North Ave Date signed 10/7/47

5825

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52 B

G55825 Registered No.

1. PLACE OF DEATH: The Mount Home
(a) Baltimore City, Maryland 3706 Nortonia Road
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2617 Loyola Southway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Simon Esterson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Late Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER
12. Name: Jacob Esterson
13. Birthplace: Russia

MOTHER
14. Maiden Name: Bertha
15. Birthplace: Russia

16 (a) Informant: Jack Esterson
(b) Address: 2617 Loyola Southway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 8, 1947 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Young Men Cemetery
Location: Windsor Mill Road

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

19 (a) Date received by registrar (b) Registrar

VS 150

MEDICAL CERTIFICATION 10.40

20. DATE OF DEATH October 7 1947, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1947 to Oct. 7 1947 and that I last saw him alive on Oct. 7 1947

Immediate cause of death: Carcinomatosis — Duration: 6 mos

Due to: Carcinomatosis - Intestines

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Paul E. Cantuner M. D.
Address: 2217 Lovith rd Date signed: 10-8-47

X

826

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 951B

Registered No. 655826

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 13 N Kenwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 13 N. Kenwood ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond V. Marvel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Ethel Marvel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 22. 1892

8. AGE: Years	Months	Days	If less than one day
55		14	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation C & P telephone Co.
11. Industry or business Supervisor

FATHER
12. Name Alfred Marvel
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth Garrison
15. Birthplace Md

16 (a) Informant Mrs Ethel Marvel
(b) Address 13 N. Kenwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 9-1947 (month) (day) (year)
(c) Cemetery or crematory Baltimore Gens. City
Location

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2005 Orleans St

19 Oct 8 1947 (Date received by Registrar) (b) Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6. 1947, at 4 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 4 1947 to Oct. 6 1947, and that I last saw him alive on Oct 6 1947.

Immediate cause of death	Duration
Cardiac Decompensation	
Due to Rheumatic Heart Dis.	
Due to Cerebral hemorrhage	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles E. MacKenna M. D.
Address 2911 E. Bells St Date signed Oct 7 1947

5827

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. C5582?

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1531 McCullough St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nash Walker

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18, 1928

8. AGE: Years	Months	Days	If less than one day
19	5	16	hr. min.

9. Birthplace Greensboro, N. C.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Nash Walker
13. Birthplace Caswell Co. N. C.

MOTHER
14. Maiden Name Bertha Watkins
15. Birthplace Caswell Co. N. C.

16 (a) Informant Mrs. Bertha Walker
(b) Address 1531 Mc Cullough St

17 (a) Burial (b) Date thereof Oct. 9, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Lee A. Holland
(b) Address 1651 Druid Hill Ave

1947 OCT 8 1947 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4 1947, at 12:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemorrhage due to Bullet Wound of Lungs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-4-47 at 12:10 P.M.
(b) Where did injury occur? Madison St & Argyle Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Firearms

23. Signature Edward L. Page M.D.
Medical Examiner
Date signed 10-4-47

5828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 823a

Registered No. C55828

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2813 Remington Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2813 Remington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie James

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Albert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov. 15, 1887

8. AGE: Years: 59 | Months: 10 | Days: 18 | If less than one day: hr. min.

9. Birthplace: Easton, Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: John Cooper
13. Birthplace: Easton, Md.

MOTHER
14. Maiden Name: ?
15. Birthplace: ?

16 (a) Informant: Mrs. George Johnson
(b) Address: 2813 Remington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct. 7, 19 47 (month) (day) (year)
(c) Cemetery or crematory: Mt. Calvary
Location: Balto. Co. Md.

18 (a) Funeral director: Mrs. George A. Holland
(b) Address: 1631 Druid Hill Ave.

19 Oct. 8 1947 (Date rec'd by registrar) Huntington Williams M.D.

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3 1947, at 11:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 3-19 1947 to Oct. 3, 6 1947, and that I last saw her alive on Oct. 3 1947.

Immediate cause of death: Cerebral hemorrhage — Duration: 1 hr 30 minutes

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

25. Signature: H. Garland Amoss

Address: 1534 Druid Hill Ave. Date signed: Oct. 7

X

828. J. Brooke Boyle

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

✓ G55829 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1702 St. Paul Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 St. Paul Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MISSOURI RIDER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Clarence Riuer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1855

8. AGE: Years	Months	Days	If less than one day
92	1	5	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name William Crouse
13. Birthplace Md.

MOTHER
14. Maiden Name Sevilla Hann
15. Birthplace Md.

16 (a) Informant Mrs. J. Brooke Boyle
(b) Address 2739 St. Paul Street

17 (a) Burial (b) Date thereof 10-9-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Emmitsburg, Md.
Location Emmitsburg, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road, 14

OCT 8 1947 (Date rec'd by registrar) (Signature) Huntington Williams M.D.

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-6- 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July-1- 1947 to Oct- 6 - 1947, and that I last saw h.r. alive on 10/6/ 1947.

Immediate cause of death	Duration
Carcinoma of Breast.	
Due to Generalized metastasis & Anemia.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Brooke Boyle M. D.
Address 3720 W. University Blvd. Date signed 10/7/47.

55830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G55830

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1725 W. Lanvale St
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1725 W. Lanvale
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES ANTHONY

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/10/1882

8. AGE: Years	Months	Days	If less than one day
65	1	25	hr. min.

9. Birthplace N.C.
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Kenneth Anthony
13. Birthplace N.C.

MOTHER
14. Maiden Name Catherine
15. Birthplace N.C.

16 (a) Informant James Anthony, Jr. (Son)
(b) Address 1011 W. Lanvale St

17 (a) Burial (b) Date thereof 10/8/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem'l. Pk.
Location Balto. County, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 510-12 N. Carrollton Ave

19 (a) OCT 8 1947 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150 · 4

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/5/47 19 , at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 19 47 to 10/5 19 47 and that I last saw [illegible] alive on 10/5 19 47.

Immediate cause of death	Duration
Arteriosclerotic Cardiovascular Disease	1 yr.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 1525 Eutaw Place Date signed 10/7/47

x 1

G55831

BALTIMORE CITY HEALTH DEPARTMENT ✓ G55831
CERTIFICATE OF DEATH 121a
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2022 E. 31st St.
(c) Hospital or institution: 9-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2022 E. 31st Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Philip Kieffner

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Emma Kieffner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1877

8. AGE: Years	Months	Days	If less than one day
69	10	14	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Charles J. Kieffner
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Harrmann
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Erma Kieffner
(b) Address 2022 E. 31st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10.9.47 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 1947 (b) Huntington Williams, M.D. Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 Oct. 1947, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 28 Sept 1947 to 6 Oct. 1947 and that I last saw h[im] alive on 4 Oct. 1947

Immediate cause of death	Duration
Chronic Glomerular Nephritis with uremia	6 mos.
Due to Hypertensive cardiovascular disease.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. H. Kammer Jr.
Address 5018 Sheridan Ave Date signed 6 Oct. 47

X

G55832 ✓ G55832

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4305 Groveland Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4305 Groveland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GRACE E. FRANKLIN

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widowed

6 (b) Name of husband or wife Benjamin Franklin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 19, 1869

8. AGE: Years	Months	Days	If less than one day
78	0	17	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles E. Oler
13. Birthplace Balto.

MOTHER
14. Maiden Name Mary C. Kennedy
15. Birthplace Ireland

16 (a) Informant Mr. Herbert A. Franklin
(b) Address 4304 Elderon Ave.

17 (a) Burial (b) Date thereof 10/9/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) [illegible] Thurlington Williams, M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6, 1947, at 8:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1946 to Oct 6 1947, and that I last saw [illegible] alive on Oct 6 1947.

Immediate cause of death	Duration
Carcinoma Right Breast	10 Month
Metastasis to Lungs	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Maynard Hilton M. D.
Address 711 Penrhyn Rd Date signed 10-7-47

X

G55833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G55833 Registered No. 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2500 Broening Highway
(c) Hospital or institution: Western Electric Co.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) /

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 5 Overbrook Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LeROY FREDERICK MATHEWS

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Marguerite Regina Mathews 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19, 1900

8. AGE: Years	Months	Days	If less than one day
47	4	17	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Mechanical Engineer
11. Industry or business Western Electric Co.

FATHER
12. Name Frederick J. Mathews
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mamie H. Reinecke
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Marguerite R. Mathews wife
(b) Address 5 Overbrook Rd., Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/47 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) [illegible] (Signature of registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6, 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1947 to Oct 6 1947 and that I last saw him alive on Oct 6 1947.

Immediate cause of death	Duration
Coronary Thrombosis	1 hr.
Due to Coronary Sclerosis	1 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. B. Von Schrader M.D.
Address 4818 Edmondson Ave Date signed Oct 7 1947

VS 150

G55834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G55834

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 526 S Chapel Gate
(c) Hospital or institution: Venners Lodge
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 11 Linden Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ALVERTA BROOKHART

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife J. Thomas Brookhart
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1853

8. AGE: Years	Months	Days	If less than one day
94	9	0	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Edward P. Standiford
13. Birthplace Baltimore

MOTHER
14. Maiden Name Amelia Henning
15. Birthplace Baltimore

16 (a) Informant Mrs. Brookhart
(b) Address 11 Linden Terrace, Towson

17 (a) Burial (b) Date thereof 10/9/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Prospect Hill Cem.
Location Towson, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) (b) Registrar

Correct age is especially important

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/7 1947, at 1045 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1947, to 10/7 1947, and that I last saw h alive on 10/7 1947.

Immediate cause of death	Duration
Cerebral Embolism	1 day
Due to Arteriosclerosis	
Due to	
Other Conditions Pertinent Arterial sclerosis	7

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 33 W Chesapeake Ave Date signed 10/7/47

Huntington Williams, Md

Formerly G55835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G55835

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Seton Balto. General

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 19 Holmehurst Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME H. Vernon Lemmon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Clara Lemmon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19, 1900

8. AGE: Years	Months	Days	If less than one day
47	3	17	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name John T. Lemmon
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Hunt
15. Birthplace Md.

16 (a) Informant Clara Lemmon
(b) Address 19 Holmehurst Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-9-47 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Baltimore

18 (a) Funeral director George A. Farley
(b) Address Baltimore & Fayette Sts.

19 (a) Filed by registrar (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1947, at 9:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1947, to Oct 6 1947, and that I last saw h— alive on Sept 27 1947.

Immediate cause of death	Duration
Coronary Thrombosis	Sept 1/47
Int. Obst.	
Due to E.K.G. Sept 30/47	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Dorsey M.D.
Address 1 Medical Arts Bldg. Date signed Oct 6/47

Correct age is especially important. Typewrite or print plainly in ink.

VS 150

655836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47c

Registered No. 655836

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 LIGHT STREET
(c) Hospital or institution:
South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town RURAL - GLEN ARM
(If outside city or town limits, write RURAL and give town)
(d) Street No. GLEN ARM.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Hugh W. Twinning

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 4 1916

8. AGE: Years	Months	Days	If less than one day
31	7	1	hr. min.

9. Birthplace Glen Arm Balto. Md
(Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Isaac J. Twinning
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Bustard
15. Birthplace Md

16 (a) Informant Isaac J. Twinning
(b) Address Glen Arm Md.

17 (a) Burial (b) Date thereof Oct. 11 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Ward Chapel
Location Glen Arm Md

18 (a) Funeral director L. E. Gothard
(b) Address Fork Md

19 (a) (Date rec'd by reg.) (b) Signature

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 8 1947 at 2 20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from OCT. 7 1947 to OCT 8 1947 and that I last saw him alive on OCT. 8 1947

Immediate cause of death	Duration
ACUTE CARDIO RESPIRATORY FAILURE	
Due to BRONCHOGENIC CARCINOMA	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy BRONCHOGENIC CARCINOMA

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature William B. Cooper Jr. M. D.
Address South. Balto. Gen. Hosp. Date signed 10/8/47

correct age is especially important. Physicians, please

VS 150

G55837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G55837 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2700 Dillon St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2700 Dillon St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Wisniewski

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-09-0947

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
About 78			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business McGees

FATHER
12. Name —
13. Birthplace Poland

MOTHER
14. Maiden Name
15. Birthplace Poland

16 (a) Informant Anna T. Brown
(b) Address 2553 Fait Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-10-47 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto Co

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern ave

19 1947 (Date rec'd by Registrar) (b) Signature for Williams, M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1947, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1947, to Oct 6 1947, and that I last saw him alive on Oct 6 1947.

Immediate cause of death	Duration
Arteriosclerosis	unknown
Due to	
Due to	
Other Conditions Myocarditis	5 months

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation —
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard Jennings Jr. M. D.
Address 107 2429 Fait Ave Date signed 10/7/47

G55838

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G55838 106 B
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Ariz (b) County
(c) City or town Phoenix
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 - E. Pierson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Audrey R. Sinnis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charles E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-4-10

8. AGE: Years 37 | Months 1 | Days 3 | If less than one day ..... hr. ..... min.

9. Birthplace S. D.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Carl Cerminyard
13. Birthplace Iowa

MOTHER
14. Maiden Name Ada Mackale
15. Birthplace Wis

16 (a) Informant Mr. Charles E. Sinnis
(b) Address [redacted] Phoenix, Ariz.

17 (a) Burial (b) Date thereof 10/10/47
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Charles City, Iowa

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw St.

19 (a) (b)
(Date rec'd by registrar) Registrar

OCT 8 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 1947 at 11:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19 1947 to Oct 7 1947 and that I last saw her alive on Oct 7 1947.

Immediate cause of death: Hemorrhage, operative
Due to: Bronchiectasis
Other Conditions:
(Include pregnancy within 3 months of death)

Duration
2 mos
12 yrs.

Date of operation 10-8-47
Major findings of operation: Bronchiectasis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert Higgins Jr. M.D.
Address Johns Hopkins Hospital
Date signed 10-8-47

Huntington Williams, M.D.

G55839

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. G55839

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3907 Hudson St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Maggie Willner
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Andrew Willner
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Nov 14 1865

8. AGE: Years	Months	Days	If less than one day
81	10	23	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Christopher Gimball
13. Birthplace Germany

MOTHER
14. Maiden Name Maggie —— ?
15. Birthplace Germany

16 (a) Informant Husband
(b) Address 3907 Hudson St

17 (a) Burial (b) Date thereof 10/11/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave

18 (a) Funeral director Blumel & Hoffmann
(b) Address 1639 Broadway

19. (a) (b) Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/7 1947, at 1:15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/7 1947 to 19 ; and that I last saw h[er] alive on 10/7 1947.

Immediate cause of death Unknown — Duration

Due to

Due to

Other Conditions Carcinoma Stomach
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Buchner M.D.
Address Mercy Hosp. Date signed 10/7/47

correct age is especially important. Physicians, please

VS 150

Huntington Williams, Md

G55840 Transcribed

BALTIMORE CITY HEALTH DEPARTMENT ✓ G55840 Registered No.

CERTIFICATE OF DEATH 467

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore Gen'l Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2403 Annapolis Road. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Katherine Bansbury

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Femal.	White	Widowed

6 (b) Name of husband or wife James D. Bansbury
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 7 - 1885

8. AGE: Years	Months	Days	If less than one day
62.	8	11	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name George Streib.
13. Birthplace Holland.

MOTHER
14. Maiden Name Unknown.
15. Birthplace Holland.

16 (a) Informant Miss Bertha Bansbury
(b) Address 2403 Annapolis Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 9-1947 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore Md.

18 (a) Funeral director Mamie Cook Lyfer
(b) Address 1600 W. North Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 8-1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6 1947, at 1 42 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/19 1947 to 10/6 1947. and that I last saw h.e.r alive on 10/6 1947.

Immediate cause of death Respiratory failure	Duration
Due to Hypertensive & arteriosclerotic heart disease.	
Due to	
Other Conditions Ca. of rectal polyps	

(Include pregnancy within 3 months of death)
Date of operation 9/20/47
Major findings of operation: rectal polypectomy ca.
of autopsy: not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —
23. Signature H. Huntington Williams
Address West Balt. Gen'l Hosp. Date signed 10/6/47 M. D.

×

G55841

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

G55841 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3223 Fleet Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3223 Fleet Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NORA E. SEIDEL BROWN

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Taring G.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 30, 1868

8. AGE: Years	Months	Days	If less than one day
79	1	8	hr. min.

9. Birthplace West Fairview, Penna.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name John A. Seidel
13. Birthplace West Fairview, Penna.

MOTHER
14. Maiden Name Elizabeth Hood
15. Birthplace Duncannon, Penna.

16 (a) Informant Mr. Harvey Seidel
(b) Address 404 S. Conkling Street

17 (a) Removal (b) Date thereof Oct. 8, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Odd Fellows
Location Danville, Penna.

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) OCT 8 1947 Washington Williamsport, Md. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8 1947, at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 3 1947, to Oct 8 1947 and that I last saw h.. alive on Oct. 7 1947.

Immediate cause of death	Duration
Bronchopneumonia	3 days
Due to Gastric Carcinoma	1 yr.
Due to	
Other Conditions Severe anemia	
Anemia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clarence W. LeBoeuf
Address 601 S. Ellwood Ave. Date signed 10/8/47

X

G55842

BALTIMORE CITY HEALTH DEPARTMENT ✓ G55842 Registered No.

CERTIFICATE OF DEATH 46E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2123 Huntingdon Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2123 Huntingdon Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary M. Batchelder

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~.
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ Daniel Batchelder
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 1870

8. AGE: Years	Months	Days	If less than one day
76 77	10		hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At. Home

FATHER
12. Name Capt. James Gourley
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary F. Weaver
15. Birthplace England

16 (a) Informant James F. Batchelder
(b) Address 2123 Huntingdon Ave

17 (a) Burial (b) Date thereof 10/9/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

Correct age is especially important

OCT 9 1947 (b)
(Date rec'd by registrar) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6th 1947, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from December 1946 to Oct. 6th 1947, and that I last saw h~~er~~ alive on Oct. 2nd 1947.

Immediate cause of death	Duration
Cardio vascular disease.	
Due to arteriosclerosis of Coronary Artery.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Nelson White M.D.
Address 3005 St. Paul St. Date signed Oct. 8th 47

X

G55843

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 181

G55843 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2249 Annapolis Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond E Berger

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 212-22-9812

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elenor M

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 20 1928

8. AGE: Years 19 Months 8 Days 17 If less than one day hr. min.

9. Birthplace: Baltimore Md (City, county, and state)

10. Usual Occupation: Sheet Metal Worker

11. Industry or business: M H Berger Inc

FATHER
12. Name: William A Berger
13. Birthplace: Balto Md

MOTHER
14. Maiden Name: Cecil Richardson
15. Birthplace: Balto Md

16 (a) Informant: Elenor Berger
(b) Address: 2249 Annapolis Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/47 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore Md

18 (a) Funeral director: Wilson & Son
(b) Address: 1219 Park Ave

19 (a) 8 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7, 1947, at 7 P. M

21. I certify that I took charge of the remains described above, held an Inspection & Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Pneumonia (Lobar)

Due to 2nd - 3rd degree burns 52% of body surface.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-4-47 at 11A. M. 25/3
(b) Where did injury occur? 2249 annapolis Blvd.
(c) Did injury occur at home, on farm, industrial place, in public place Berger Corp., 2249 anna. Blvd. While at work?
(d) Means of injury Heating tank of turpentine clothes

23. Signature Earl K Long M.D. (Medical Examiner)

Date signed 10/8/47

G55844 ✓G55844

AB-114262

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3days
(e) Length of stay in Baltimore (yrs., mos., or days) 5yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Parkville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2714 Glendale Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John T. Whitehurst

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6- 1859

8. AGE: Years	Months	Days	If less than one day
87	10	1	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Whitehurst
13. Birthplace Virginia

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Virginia

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) removal (b) Date thereof 10/8/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Forest Lawn
Location Norfolk, Virginia

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) 1947 (b) Registrar
(Date rec'd by registrar)

VS 150 To be approved by Medical Examiner

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7- 1947, at 4.40P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-4- 1947 to 10-7 1947, and that I last saw h. im alive on 10-7 1947.

Immediate cause of death Generalized arteriosclerosis — Duration 10 years.

Due to

Due to

Other Conditions Comminuted fracture L/F femur. — 4 days.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Generalized arteriosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 10-3-47 at 7 P.M.
(c) Where did injury occur? Baltimore (City or town) Md. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home. While at work? no.
(Specify type of place)
(e) Means of injury? Fell downstairs.
23. Signature [illegible] M. D.
Address 4940 Eastern Ave Date signed 10-8-47

for P.C.J. Zubrucki by Howard J. Mercier, M.D.

G55845

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G55845

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5629 Reisterstown Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5629 Reisterstown Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Aires

3 (b) If veteran, name war ********** | 3 (c) Social Security Account No. 212-12-5647

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elsie A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 18, 1865

8. AGE: Years	Months	Days	If less than one day
82	1	18	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation (Retired) Foreman
11. Industry or business Box Indrustry

FATHER
12. Name Andrew J. Aires
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Clarissa Miller
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Johanna Seibert
(b) Address 5629 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-9-47 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director LORING BYERS
(b) Address 5005 Park Heights Ave.

19 (a) 1947 (Date rec'd by registrar) (b) [illegible] Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6, 1947 at 7P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 28 1947 to Oct 6 1947 and that I last saw h[illegible] alive on Oct 6 1947

Immediate cause of death Cerebral Hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Johanna Seibert M. D.
Address 5005 Park Heights Ave Date signed 10/7/47

5846

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G55846

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hosp. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Wilson

3 (b) If veteran, name war	3 (c) Social Security Account No.
Unknown	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
49			hr. min.

9. Birthplace Maryland, place unknown
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name George Wilson
13. Birthplace Md - Unknown city

MOTHER
14. Maiden Name Rose Mackelroy
15. Birthplace Md - city unknown

16 (a) Informant From pt's record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/47 (month) (day) (year)
(c) Cemetery or crematory Mt. Cathedral
Location [illegible] 1947

18 (a) Funeral director Wm. J. Cunningham & Sons
(b) Address Lombard - Eutaw Sts

19 OCT 8 1947 (Date rec'd by registrar) (Signature) Williams M.D. Registrar

correct age is especially important.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2, 1947, at 7:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1947 to Oct 2 1947, and that I last saw him alive on Oct. 2 1947.

Immediate cause of death	Duration
Myocardial Infarction	
Due to	
Due to	
Other Conditions Malnutrition; Urethral Stictures	—

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. W. Hollingsworth
Address Univ. Hosp. Date signed 10/6/47 M. D.

X

G55847

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

G55847 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2200 Bank St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2200 Bank St. (If rural give location)
(e) Citizen of foreign country? N.e. (Yes or No) If yes, name country

3 (a) FULL NAME Joseph George Rauh

3 (b) If veteran, name war 40

3 (c) Social Security Account No.

4. Sex m/c

5. Color or race white

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Helen Hawickhorst

6 (c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.) June 22, 1861

8. AGE: Years 86 | Months 3 | Days 15 | If less than one day ..... hr. ..... min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation wood-worker

11. Industry or business

FATHER
12. Name John Rauh
13. Birthplace Germany

MOTHER
14. Maiden Name Anna ?
15. Birthplace Germany

16 (a) Informant Helen Rauh
(b) Address 2200 Bank St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/10/47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director M. W. E. Degel's Sons
(b) Address Lombard & Ann Sts.

19 (a) 10 1947 (b) Date rec'd by registrar Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1947 to Oct 7 1947, and that I last saw h— alive on Oct 6 1947.

Immediate cause of death Carcinoma of oesophagus — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis Haeuke M. D.
Address 1 E Chase St Date signed

G55818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G55818

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 519 N. Madeira (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME John Garzola

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) ? 1867

8. AGE: Years 79 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Grape Maintenance

11. Industry or business B. & Penn.

FATHER
12. Name Joseph Garzola
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-9-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Frank Brachbon
(b) Address 900 W. Chester St

19 (a)..... (b)..... (Date rec'd by registrar) Registrar

OCT 8 1947 Huntington Williams, M.D.

Correct age if especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6 1947 at 12:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 1947 to Oct 6 1947 and that I last saw h[illegible] alive on Oct 6 1947

Immediate cause of death: Hypertension — Duration: 7 Yrs
Due to: Left hemiplegia — Duration: 1 wks
Due to.....
Other Conditions.....
(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work? (Specify type of place)
(e) Means of injury.....

23. Signature Louis H Leonard M. D.
Address Johns Hopkins Hosp Signed 10 Oct 47

G55849 N 1 112889

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G55849 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 450 E. Lanvale St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daisy Thomas

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife Jesse
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 16, 1897

8. AGE: Years	Months	Days	If less than one day
50 50	1	21	hr. min.

9. Birthplace Florida (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 10-1947 (month) (day) (year)
(c) Cemetery or crematory Parkview Cem.
Location Forest Park, Georgia

18 (a) Funeral director Elroy B. Wilson
(b) Address 1004 Blanton Ave

19 (a) Oct 8 1947 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

correct age is especially important

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6 1947 5:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 7, 1947 to Oct. 6 1947 and that I last saw her alive on Oct. 6 1947

Immediate cause of death	Duration
Hypertension and C-V Disease & Cardiac Decompensation.	
Due to	
Due to	
Other Conditions Uremia.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert A. Fallen M. D.
Address Balto. City Hosp. Date signed 10-6-47

5850 BALTIMORE CITY HEALTH DEPARTMENT 655850

CERTIFICATE OF DEATH ✓ 164 c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1527 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY H. HINES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single, married, widowed, or~~ divorced. Divorced

6 (b) Name of ~~husband or~~ wife Kathryn Hines

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 17 1906

8. AGE: Years 41 | Months 1 | Days 21 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Maintenance Mans

11. Industry or business Johns Hopkins Hospital

FATHER
12. Name (Unknown) Hines
13. Birthplace Md.

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Kathryn Hines
(b) Address 754 W. Balto. St.

17 (a) Burial (b) Date thereof 10/9/47
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto.
Location " Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

OCT 9 1947
(Date rec'd by registrar) Huntington Williams M.D.

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8, 1947 at 10 a.m. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-8-47 at 9.30 a.m. M.
(b) Where did injury occur? B. & O. R. R. Fulton avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work?
(d) Means of injury Firearms--Self inflicted

23. Signature George S. Merrill M.D.
Medical Examiner.
Date signed 10-8-47

X

5851 — G55851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 2Hrs.-25Min
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 3903 Northern Parkway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: Baby Boy Lemmons

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: M.

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 10/7/47

8. AGE: Years | Months | Days | If less than one day: 2 hr. 25 min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation:

11. Industry or business:

FATHER
12. Name: Thomas Houston Lemmons
13. Birthplace: Knoxville Tennessee

MOTHER
14. Maiden Name: Jean Eugenia Welsh
15. Birthplace: Baltimore Maryland

16 (a) Informant: Thomas Lem Mons
(b) Address: 3903 Northern Pkwy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10/9/47 (month) (day) (year)
(c) Cemetery or crematory: Balto.
Location: " Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 127 St. Paul St.

19 (Date received by Registrar) (Signature of Registrar)

VS 150

correct age is especially important

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-8-47, 19..., at 2:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-7 1947 to 10-8 1947 and that I last saw him alive on 10-6 1947

Immediate cause of death: Respiratory Failure — Duration:

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: C.W. Fisher

Address: Bon Secours Hosp Date signed: M. D. 10-8-47

5852 G55852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 743 E 28th (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Rose Perrgoy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Preston Perrgoy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-27-87

8. AGE: Years	Months	Days	If less than one day
56	3	8	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation HW
11. Industry or business

FATHER 12. Name Michael Kenny
13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Burnbing ham
15. Birthplace Balto

16 (a) Informant Hobart Kenny
(b) Address 743 E 28th

17 (a) Burial (b) Date thereof 10/10/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) 9 1947 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-8 1947 at 12 3/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-27 1947 to 10-8 1947 and that I last saw h. alive on 10-8 1947.

Immediate cause of death Lung Trouble — Duration
Secondary Liquid Pneumonia — 13 Days
Due to Hypostatic Pneumonia — 5 Days
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature H. R. Bal
Address Mercy Date signed 10-8-47 M. D.

correct age is especially important. Physicians, please

X

5853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 937

G55853 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 408 N Lemmond Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 408 N Lemmond Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna May Burns

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Edward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23, 1891

8. AGE: Years 56 Months 5 Days 17 If less than one day hr. min.

9. Birthplace Hanover Pa (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Johnson Walter

13. Birthplace Pa

MOTHER 14. Maiden Name Kelton Capp

15. Birthplace Pa

16 (a) Informant Edward A Burns

(b) Address 804 E Old Town Lane

17. Burial (Burial, cremation, or removal) (b) Date thereof 10/11/47 (month) (day) (year)

(c) Cemetery or crematory Prospect Hill

Location York Pa

18 (a) Funeral director Wilson Coble Inc

(b) Address 1214 W Fort St

19 (c) 9 1947 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 1947, at 9:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1947 to Oct 7 1947, and that I last saw h[illegible] alive on Oct 7 1947.

Immediate cause of death: myocardial insufficiency — Duration: 10 min.
Due to: acute cardiac dilatation — 1
Due to: myocarditis
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L C Coblentz

Address 447 N. Kenwood Ave Date signed 10/8/47

Correct title of respondent, if applicable

854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G55854
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2016 N. Washington St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2016 N. Washington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Guglielma Salvioni

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1880

8. AGE: Years	Months	Days	If less than one day
67	7	14	hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mary Davis
(b) Address 2016 N. Washington St.

17 (a) Burial (b) Date thereof 10/10/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Ta ylor Ave., Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03-05 E. Madison Street

19 (a) OCT 9 1947 (b) Huntington Williams M.D.
(Date received) (Registrar)

VS 150

Correct age is especially important for those under 1 year, 5 years, 10 years, 20 years, and each 10 years thereafter.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-6-47 19 , at 10 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-2-47 19 to 10-6-47 and that I last saw h[illegible] alive on 10-6-47 19

Immediate cause of death	Duration
Arteriosclerotic Cardiac - vascular Failure	
Due to	
Due to	
Other Conditions Intestinal Obstruction	6 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Costantino, M.D.
Address 234 S. Conkling St. Date signed 10-8-47

855

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G55855 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3161 Keswick Road.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 5

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3161 Keswick Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Ulysses G. Taylor.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Effie L. Taylor
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) March 5, 1873

8. AGE: Years	Months	Days	If less than one day
74	7	1	..... hr. ..... min.

9. Birthplace Maryland.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name George W. Taylor.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Elizabeth Morris.
15. Birthplace Maryland.

16 (a) Informant Effie L. Taylor.
(b) Address 3161 Keswick Road.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof 10/9/47 (month) (day) (year)
(c) Cemetery or crematory Moreland Park.
Location Taylor Ave.

18 (a) Funeral director Chenoweth & Donovan.
(b) Address 3615 17 Chestnut Ave.

OCT (a) 9 1947 (Date rec'd by registrar) Huntington Mitchell M.D.

VS 150

correct age is especially important. Physicians, please

MEDICAL CERTIFICATION A.

20. DATE OF DEATH October 6, 1947, at 11.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1st 1947 to Oct 6th 1947, and that I last saw him alive on Oct 6th 1947.

Immediate cause of death Coronary Occlusion — Duration 2 days

Due to Cerebral Arteriosclerosis — 5 yrs.

Due to Chronic Nephritis — 6 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H A Linsert M. D.
Address 714 Fox Bldg Date signed 10/5/47

X

5856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946 B

Registered No. G55856

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Park Heights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-12
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3520 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Celia Friedman

3 (b) If veteran, name war ~ | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife Sete Louis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28 1883

8. AGE: Years 64 | Months 2 | Days 11 | If less than one day ..... hr. ..... min.

9. Birthplace Latvia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Harris Goplan
13. Birthplace Latvia

MOTHER
14. Maiden Name Tobia
15. Birthplace Litvia

16 (a) Informant Lillian Friedman
(b) Address 3520 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 9 47 (month) (day) (year)
(c) Cemetery or crematory Shomrie Zion Cemetery
Location Rosedale

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-26 W. North Ave

19 (a) Oct 9 1947 (Date rec'd by Registrar) (b) [illegible]

Correct age is especially important if deceased is under one year or one day old.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8 1947 19 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to Oct 8 1947 and that I last saw her alive Oct 8 47 1947

	Duration
Immediate cause of death Gastric hemmorrhage (concealed)	1 day
Due to Cancer of Stomach	April 1947
Due to (cardiac end)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 7/31/47

Major findings of operation: Inoperable cancer of Stomach

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton E. Lonman M. D.
Address 4643 Park Heights Ave Date signed 10/6/47.

857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G55857

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — Sinai Hospital
(b) Street address — Monument & Rutland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) — 15
(e) Length of stay in Baltimore (yrs., mos., or days) — 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State — Md (b) County
(c) City or town — Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. — 3633 Cottage Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME — JACOB BROWN.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male M.	White	Married

6 (b) Name of husband or wife — Sarah G.

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) — April 6, 1889

8. AGE: Years	Months	Days	If less than one day
58	6	2	____ hr. ____ min.

9. Birthplace — Russia
(Town, county, and state)

10. Usual Occupation — Merchant

11. Industry or business

FATHER
12. Name — Isaac Brown
13. Birthplace — Russia

MOTHER
14. Maiden Name — Zelda Rich
15. Birthplace — Russia

16 (a) Informant — Arnold Brown
(b) Address — 3633 Cottage Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof — Oct 9, 1947 (month) (day) (year)
(c) Cemetery or crematory — Hebrew Rosedale Cem
Location — Hamilton Ave

18 (a) Funeral director — Sol Levinson & Bros
(b) Address — 1124-1126 W North Ave

19 OCT 9 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH — Oct. 8 1947, at 1140 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21 1947 to Oct 8 1947 and that I last saw him alive on Oct 8 1947

Immediate cause of death — Uraemia & Congestive Heart Failure. — Duration: 11 mths

Due to — Chronic Nephritis — Duration: 1

Due to — Hypert. and Arteriosclerotic H.D. — Duration: 1

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature — Oscar Kramer M.D.

Address — Sinai Hospital — Date signed — 10/9/47

X

5858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G55858 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-9
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 602 Perkins Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Henry Walker / Walker

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	B	Married

6 (b) Name of husband or wife [illegible] Mollie
6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) 9-1905

8. AGE: Years	Months	Days	If less than one day
42	1	7	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Shipping Clerk
11. Industry or business Shipping

FATHER
12. Name Jack Walker
13. Birthplace Va

MOTHER
14. Maiden Name Sally ?
15. Birthplace Va

16 (a) Informant wife
(b) Address same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-11-47 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Maryland.

18 (a) Funeral director William J. Jackson
(b) Address 946 Penna. Ave.

19 (a) 9 1947 (Date filed by registrar) (b) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-8 1947 at 7 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-27 1947 to 10-8 1947 and that I last saw h/ alive on 10-8 1947

Immediate cause of death	Duration
Uremia Glomerulo Nephritis	
Due to CVAD	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature M. D.
Address Mercy Date signed 10-9

correct age is especially important. Physicians: please write

VS 150

5859

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G55859

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3835 S. Hanover St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25+
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3835 S. Hanover St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Strickler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Wm. H. Strickler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 26-1877

8. AGE: Years 70 | Months - | Days -12 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Chas C. Hesselbacker
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Schaeffer
15. Birthplace Germany

16 (a) Informant William B. Strickler
(b) Address 3835 Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location Frederick Road Balto.

18 (a) Funeral director Milton Schelling
(b) Address 3914 Hanover St 26

19 (a) (Date received by registrar) (b)

VS 150

correct age is especially important

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8th 1947, at 11.55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1934 to Oct. 8 1947; and that I last saw h[illegible] alive on Oct. 8 1947.

Immediate cause of death	Duration
Cerebral Thrombosis	1 day
Due to Hypertension Cardio Vascular Disease	
Due to	
Other Conditions Nervous Thrombosis and Hemiplegia	1934

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul Luttrell M.D.
Address 320 Intapsco Circle Date signed 8/6/48

5860

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 93E

G55860
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 730 Bradley Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JERMIAH RUSSELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Susana Russell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1907

8. AGE: Years 40 | Months 1 | Days 6 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Isaiah Russell
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Emma Broaden
15. Birthplace Baltimore, Md.

16 (a) Informant Robert H. Russell
(b) Address 783 W. Santo Goal St

17 (a) Burial (b) Date thereof Oct. 12, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Kate R. Williams
(b) Address 327 N. Schroeder St

19 (a) OCT 9 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/7/47 1947, at 2:15 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Cardiac Failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner
Date signed 10/9/47

5861

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓93E

G55861
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1511 West Fairmount Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1511 West Fairmount Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clarence Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife Eliza Green

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Blacksburg, S.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Neal Green.
13. Birthplace N.C.

MOTHER
14. Maiden Name Ettie
15. Birthplace N.C.

16 (a) Informant Sadie Kelley.
(b) Address 606 N. Eden St.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Oct. 13, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 322 N Schroeder St

19 (a) Interring Wm Williams M.M. (Date rec'd by Registrar) Registrar

OCT 9 1947

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7 1947, at 12:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute congestive cardiac failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D. Medical Examiner.
Date signed 10-7-47

55862

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 655862

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 733 Eislin Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 733 Eislin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nancy Washington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
f	c	Widow

6 (b) Name of husband or wife Lindsay Washington
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25, 1879.

8. AGE: Years	Months	Days	If less than one day
68	4	13	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Thomas Spriddle
13. Birthplace Md.

MOTHER
14. Maiden Name Nancy
15. Birthplace Md.

16 (a) Informant Nellie Spriddle
(b) Address 668 Shaw St.

17 (a) Burial (b) Date thereof Oct. 11, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Laurel
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 OCT 9 1947 Henrietta for Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/7/47 19 at 8:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 10/7/47

5863

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V. 13 B

G55863
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 564 Dolphin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 564 Dolphin St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph B. Sawyer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Negro	Married

6 (b) Name of husband or wife Flossie Sawyer
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) 9-27-93

8. AGE: Years	Months	Days	If less than one day
54	—	10	....hr. ....min.

9. Birthplace New Bern, N. C.
(Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business Hirsch Tailoring Co.

FATHER
12. Name Richard Sawyer
13. Birthplace N. C.

MOTHER
14. Maiden Name Emma Sawyer
15. Birthplace N. C.

16 (a) Informant Flossie Sawyer
(b) Address 564 Dolphin St.

17 (a) Burial (b) Date thereof 10-10-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md.

18 (a) Funeral director Charles P. Law
(b) Address 802 Madison Ave

10-9 1947 (b) Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

1818

VS 150

correct age is especially important. Physicians, please

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/7 1947, at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 10 1947, to Oct. 7 1947, and that I last saw him alive on Oct. 7 1947.

Immediate cause of death	Duration
Pulmonary T.B.,	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature C D Lee M. D.
Address 2530 - Pt. Ave Date signed 10-8-47

X

5864

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G55864

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 934 N. Stricker
(c) Hospital or institution:
16 D
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits write RURAL and give town)
(d) Street No. 934 N. Stricker
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William A. Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	M

6 (b) Name of husband or wife Clara E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22 1881

8. AGE: Years	Months	Days	If less than one day
66	7	17	hr. min.

9. Birthplace Cumberland Va.
(Town, county, and state)

10. Usual Occupation Minister

11. Industry or business

FATHER
12. Name Joseph Harris
13. Birthplace Va.

MOTHER
14. Maiden Name Amelia Lipscomb
15. Birthplace Va.

16 (a) Informant Clara E. Harris
(b) Address 934 N. Stricker St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 10-13 47 (month) (day) (year)
(c) Cemetery or crematory M. Hill
Location Balto. Md.

18 (a) Funeral director Samuel W. Sullivan Jr
(b) Address 1911 N. Arlington Ave.

19 (a) OCT 9 1947 (date rec'd by registrar) (b) Huntington Williams M.D. Registrar

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-9 1947 at 4.50 A. M

21. I certify that death occurred on the date above stated, that I attended deceased from 9-29 19 47 to 10-9 19 47 and that I last saw h[illegible] alive on 10-9 19 47

Immediate cause of death: Carcinoma of the Cardia — Duration: one year

Due to: Acute Dilatation

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]

Address 1911 N. Arlington Ave. Date signed 10-13-47

Correct age is especially important. Please answer all questions.

5865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G55865

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2822 W. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-6
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2822 W. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT GUY SPEDDEN

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Bertha Spedden
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 9, 1872

8. AGE: Years	Months	Days	If less than one day
75	8	27	hr. min.

9. Birthplace Dorchester Co., Md. (Town, county, and state)
10. Usual Occupation Retired B. & O. R. R.
11. Industry or business Freight Clerk

FATHER
12. Name Urightson Spedden
13. Birthplace Dorchester Co., Md.

MOTHER
14. Maiden Name Clara Spedden
15. Birthplace Dorchester Co., Md.

16 (a) Informant Mrs. Bertha Spedden
(b) Address 2822 W. North Ave.

17 (a) Burial (b) Date thereof (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 OCT 9 1947 Registrar for Williams, M.D.
(Date rec'd by Registrar)

VS 150

correct age is especially important. Physicians, please w

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6, 1947 at 2:15A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1947 to Oct 6 1947 and that I last saw living on Oct. 5 1947.

Immediate cause of death	Duration
Edema of lungs	1 Day.
Due to Chr. Myocarditis	5 yrs.
Due to	
Other Conditions Advanced arteriosclerosis, (Include pregnancy within 3 months of death)	10 yrs.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. E. Wells M. D.
Address 4100 Edmondson Ave Date signed Oct 7, 1947

5866

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 655866

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2309 Avalon Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-4
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2309 Avalon Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELSA L. HARDEN

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Frederick W. Harden, Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1880

8. AGE: Years 66 | Months 9 | Days 24 | If less than one day 13 hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph P. Lucas
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Edith MacGuire
15. Birthplace N. Y.

16 (a) Informant Mr. Frederick W. Harden, Sr.
(b) Address 2309 Avalon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/10/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 9 1947 (Date rec'd by Registrar) (b) [illegible] Registrar

correct age is especially important. Physicians please write plainly.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1947, at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 24 1947 to Oct 6 1947, and that I last saw h[illegible] alive on Oct 6 1947.

Immediate cause of death	Duration
Coronary Thrombosis	Sudden
Due to Diabetes Mellitus,	Several yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M Brennan Ford M. D.
Address 2200 Garrison Blvd Date signed 10/8/47

5867

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. 655867

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2662 W. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna F. TURCO

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife James Turco
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10, 1882

8. AGE: Years	Months	Days	If less than one day
65	6	27	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Prager
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Schaft
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. James Turco
(b) Address 2662 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/47 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 OCT 9 1947 (Date rec'd by registrar) (b) Huntington Williams (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7 1947 at 5:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1 1947 to Oct 7 1947, and that I last saw h[illegible] alive on Oct 7 1947.

Immediate cause of death	Duration
Cholemia	
Due to Stricture of hepatic ducts.	
Due to Neoplasm.	
Other Conditions Gall. duct chronic peritonitis.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Stricture of hepatic duct by neoplasm
of autopsy: probably malignant

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard Fuches M.D.
Address West Balt Gen'l Date signed 10/8/47 M. D.

correct age is especially important. Typewrite or print plainly in ink.

VS 150

55868 B.C. B. 1907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1579

Registered No. C55868

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Gen'l. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2515 W. Lanvale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** INFANT STEPHEN DOUGLAS NEWCOMB

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife –
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1947

8. AGE: Years	Months	Days	If less than one day
–	–	8	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation –
11. Industry or business –

FATHER
12. Name Frederick G. Newcomb
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Phyllis Atkins
15. Birthplace Roanoke, Va.

16 (a) Informant Mrs. L. W. Newcomb
(b) Address 764 Charing Cross Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/47 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 9 1947 (Date rec'd by Registrar) (b) [illegible] Registrar

correct age is especially important. Typewriter process. Typewriter ribbon.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8 1947, at 3:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1947 to Oct 8 1947 and that I last saw him alive on Oct 8 1947.

Immediate cause of death premature — Duration

Due to intestinal obstruction

Due to peritonitis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation Oct 7 '47
Major findings of operation: atresia of large bowel
of autopsy: peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address West Balt. Gen. Hosp. Date signed Oct 8 '47 (M. D.)

5869

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 46 B

Registered No. 655869

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette St
(c) Hospital or institution: Franklin Sq Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore (Baldwin, Md)
(c) City or town Box 42 Baldwin Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. Box 42 Baldwin Md.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Cromwell John (John Calvin Cromwell)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Angelina Cromwell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21 1883

8. AGE: Years	Months	Days	If less than one day
64	2	17	hr. min.

9. Birthplace Baltimore County (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business —

MOTHER / FATHER

12. Name James Cromwell

13. Birthplace Baltimore Co Md

14. Maiden Name Mary Anne Dawson

15. Birthplace Dayne

16 (a) Informant from chart

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/47 (month) (day) (year)

(c) Cemetery or crematory Mt. Zion M.E. Location Long Green Md

18 (a) Funeral director Robert F. Cromwell

(b) Address 1562 Carlton St

OCT 9 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 1947, at 8:42 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/13 1947 to 10/7 1947 and that I last saw h[illegible] alive on 10/7 1947.

Immediate cause of death Myocardial Failure — Duration 1 Days

Due to Cancer of the Stomach & metastasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: Carcinoma of Stomach

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Michael R Lamond M.D.

Address Franklin Sq Hosp Date signed 10/7/47

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write plainly.

5870 BALTIMORE CITY HEALTH DEPARTMENT Registered No. G55870

CERTIFICATE OF DEATH 567

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Caroline
(c) City or town Denton (rural)
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy M Flaharty

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1935

8. AGE: Years	Months	Days	If less than one day
11	10	2	hr. min.

9. Birthplace Caroline Co. (Town, county and state)
10. Usual Occupation child
11. Industry or business

FATHER
12. Name Clinton Flaharty.
13. Birthplace Caroline Co. Md.

MOTHER
14. Maiden Name Ida Allen.
15. Birthplace Talbot Co Md

16 (a) Informant Clinton Flaharty.
(b) Address Preston Md. R.F.D.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 11 47 (month) (day) (year)
(c) Cemetery or crematory Preston
Location Preston Md.

18 (a) Funeral director J J Trappe Son Den
(b) Address Federalsburg Md.

19 Oct 9 1947 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8 1947 at 1:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 3 1947 to Oct 8 1947, and that I last saw her alive on Oct 8, 1947.

Immediate cause of death	Duration
Postoperative respiratory collapse - Medullary	
Due to Uterus & Ovarian postoperative	
Due to	none
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 10-7-47
Major findings of operation: Multiple posterior pararectal tumors
of autopsy: Uterus

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J E Evans M.D.
Address Main, Hoop. Date signed 10/9/47

correct age is especially important. Physicians: please write plainly.

VS 150

G55871

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V. 13 B

G55871
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1707 Baker Street.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1707 Baker Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Ball

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 11/9/23

8. AGE: Years	Months	Days	If less than one day
23	10	29	hr. min.

9. Birthplace Balto - Md
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Wm Ball
13. Birthplace Va

MOTHER
14. Maiden Name Edith Jones
15. Birthplace Va

16 (a) Informant Edith Ball
(b) Address 1707 Baker St
17 (a) Burial (b) Date thereof 10/11/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md
18 (a) Funeral director Geo. U. Kelson
(b) Address 1363 Pressstman St
19 (a) Date received by registrar OCT 9 1947 (b) Registrar Huntington Williams

VS 131

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8, 1947, at 1.20 P M

21. I certify that I took charge of the remains described above, held an insp. & inq. (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the cause of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil C. Rogers M.D.
Medical Examiner.
Date signed 10-9-47

G55872

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G55872 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1713 N. Dallas St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willie El Faison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	colored	Married

6 (b) Name of husband or wife Lillian

6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) 3-2-86

8. AGE: Years	Months	Days	If less than one day
61	7	5	..... hr. ..... min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Minister Science Temple

11. Industry or business

FATHER
12. Name Lawerence El Faison
13. Birthplace North Carolina

MOTHER
14. Maiden Name ? Magaret
15. Birthplace North Carolina

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Cremation (b) Date thereof 10/11/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Md.

18 (a) Funeral director Geo. A. Kelso
(b) Address 1303 Pennsylvania Ave

19 (a) ..... (b) .....
(Data rec'd by registrar) Registered

correct age is especially important

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7 1947, at 1022 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 5 1947 to Oct. 7 1947, and that I last saw h.i.m alive on Oct. 7 1947.

Immediate cause of death	Duration
Lymphosarcoma	2 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert E. Mason M. D.

Address Johns Hopkins Hosp. Date signed 7 Oct '47

G55873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1316

G55873 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 722 E. Biddle St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 722 E. Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie A. Ridenour

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Charles E. Ridenour
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.) Dec 18, 1878
8. AGE: Years 68 | Months 9 | Days 23 | If less than one day: hr. min.
9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business at Home

FATHER
12. Name Michael Murray
13. Birthplace Ireland

MOTHER
14. Maiden Name not known
15 Birthplace Ireland

16 (a) Informant Mrs. Frances J. Ridenour
(b) Address 722 E. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 11, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location 2930 Frederick Rd

18 (a) Funeral director Elsinger & Coughlin Sons
(b) Address 924 E. Eager St.

19 (a) (Date rec'd by registrar) (b) Registrar

correct age is especially important, and should be given in years if known, or even approximately, even if deaths occur in infancy.

V 2 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8, 1947, at 8:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 20 Ct. 1947, to 8 Oct. 1947, and that I last saw her alive on 7 Oct. 1947.

Immediate cause of death: Chronic Nephritis with Uremia — Duration: 1 1/2 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Wm. H. Kammer, Jr.
Address 501 Sheridan Ave. Date signed Oct. 1947

G55874

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G55874
Registered No.

AB-114504

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 229 N. Wolfe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Betty Ann Owens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18- 1945

8. AGE: Years	Months	Days	If less than one day
1	9	21	hr. min.

9. Birthplace S.C.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Owens
13. Birthplace S.C.

MOTHER
14. Maiden Name Marie Black
15. Birthplace S.C.

16 (a) Informant Records-Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Oct. 12. 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hopewell Cem
Location Strother S. C.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bentley ave

19 (a) (b)
Date of d... Registrar ... Registered

OCT
VS 150

correct age is especially important...

MEDICAL CERTIFICATION

AM

20. DATE OF DEATH October 8- 1947, at 12.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-6- 1947, to 10-8 1947, and that I last saw h. or alive on 10-8 1947.

Immediate cause of death	Duration
Tuberculous Meningitis	1 wk.
Due to	
Due to	
Other Conditions Pulmonary Tuberculosis	1 mo.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Tbc Meningitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Julian P. Griffin M. D.
Address Balt. City Hosps. Date signed 8 Oct 1947

X

G55875 | BALTIMORE CITY HEALTH DEPARTMENT | G55875

CERTIFICATE OF DEATH 92 B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Le
(c) Hospital or institution: Home Jas Thos Lloyd Dorsey
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hannah Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	W.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 31, 1853

8. AGE: Years	Months	Days	If less than one day
93	11	9	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Robert Phelps
13. Birthplace

MOTHER 14. Maiden Name Hannah Bennet
15. Birthplace

16 (a) Informant Gill Smith Jr Son
(b) Address 1201 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 13, 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore

18 (a) Funeral director Rita Wendelfeld
(b) Address 900 E. Biddle St

19 (a) Twistington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9, 1947, at 3:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1947, to Oct 9 1947, and that I last saw h alive on Oct 8 1947.

Immediate cause of death	Duration
Edema Lungs	3 day
Due to Mitral Stenosis	5 yrs
Due to	
Other Conditions Arterio Sclerosis	10 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Gill Hall
Address 1631 E. North Av Date signed 10/9/47 M. D.

VS 150

correct age is especially important

X

G55876

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G55876 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St. 10
(c) Hospital or institution:
Home for the Aged Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Diehl

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) June 27, 1856

8. AGE: Years	Months	Days	If less than one day
91.	3	11	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Diehl

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace Maryland

16 (a) Informant Sallie Linder 2 Nephew

(b) Address 1200 Valley St

17 (a) Burial (b) Date thereof Oct 11 1947
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director Rita Wiedefeld

(b) Address 900 E. Biddle St

19 (a) Rec'd by registrar (b) Clayton Williams, M.D. Registrar

VS 150

Correct age is especially important. Physicians, please

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 5 1947, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1947, to Oct 8 1947, and that I last saw him alive on Oct 8 1947.

Immediate cause of death	Duration
Edema Lungs	5 days
Due to Chronic Myocarditis	7 yrs
Due to	
Other Conditions Arteriosclerosis	16 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Gill Hall M. D.

Address 1631 E. North Av. Date signed 10/9/47

G55877

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82a

G55877
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 416 E Randall
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 416 E Randall
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William R Green

3 (b) If veteran, name war No

3 (c) Social Security Account No. [redacted]

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Lillian K Green

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Feb 14, 1891

8. AGE: Years 56 | Months 7 | Days 24 | If less than one day ___ hr. ___ min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Shipping Clerk

11. Industry or business Southern Ice Mills

FATHER 12. Name Green

13. Birthplace Balto Md

MOTHER 14. Maiden Name Mary J Thomas

15. Birthplace W. Va

16 (a) Informant Lillian K Green

(b) Address H/o E Randall

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 10, 1947 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Md

18 (a) Funeral director A. Harry Evans

(b) Address 1402 S Charles St

19 (a) (Date received) (Registrar) Huntington Williams, M.D. Registrar

OCT

VS 150

correct age is especially important. Physicians: please

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8th 1947, about 1230 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 7 19 47 to Oct 8 19 47 and that I last saw h alive on Oct 7 19 47

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to Hypertension	1 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Howard Evans

Address [illegible] Randall Date signed Oct 8 1947 M.D.

X

G55878 G55878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1508 Riverside Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 H
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1508 Riverside Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Elmer Kendall

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mildred G. Travers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/2/1894

8. AGE: Years	Months	Days	If less than one day
53	3	5	hr. min.

9. Birthplace Rock Hall, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles O. Kendall
13. Birthplace Md.

MOTHER
14. Maiden Name Florence Dudas
15. Birthplace Md.

16 (a) Informant Family
(b) Address 1508 Riverside Ave.

17 (a) B (Burial, cremation, or removal) (b) Date thereof 10/11/47 (month) (day) (year)
(c) Cemetery or crematory Wesley Chapel
Location Rock Hall, Md.

18 (a) Funeral director James F. McCarthy
(b) Address 130 E. Fort Ave.

Oct 13 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 1947, at 8:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1947 to Oct 1947.
and that I last saw him alive on Oct 7 1947

Immediate cause of death	Duration
(a) Coronary Occlusion	10 minutes
Due to (b) Coronary Sclerosis	8 yrs
Due to (c) Arteriosclerosis	2
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter Kohr M. D.
Address 1026 Fort Ave Date signed 10/9/47

X

Correct age is especially important. Physicians, please

G55879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G55879 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 121 E. Randall St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 121 E. Randall Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jackson E. Rose

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: M
6 (b) Name of husband or wife: Anna T. Kaufman
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): 1/29/1890
8. AGE: Years 57 | Months 8 | Days 7 | If less than one day hr. min.
9. Birthplace: Baltimore, Md (Town, county, and state)
10. Usual Occupation: Oil Treater
11. Industry or business: Con. Oil Co.

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden Name: Unknown
15. Birthplace

16 (a) Informant: Family
(b) Address: 121 E. Randall Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/10/47 (month) (day) (year)
(c) Cemetery or crematory: Cedar Hill
Location: Brooklyn, Md.

18 (a) Funeral director: James L. McCauley
(b) Address: 130 E. Fort Ave.

19 (a) 1947 (Date rec'd by registrar) (b) Registrar: Huntington Williams, M.D.

VS 150

Correct age is especially important. Physicians, please

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 6 1947, at 4P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1946, to Oct 1947, and that I last saw h. alive on Oct. 6 1947.

Immediate cause of death: Coronary occlusion — Duration: 1 day
Due to: Coronary Thrombosis — 1 yr
Due to: Arteriosclerosis — 8 yrs
Other Conditions: Cardiac vascular disease
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Walter Kohn M.D.
Address: 102 E. Fort Ave. Date signed: 10/7/47

G55880 BALTIMORE CITY HEALTH DEPARTMENT G55880

CERTIFICATE OF DEATH 1937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Old Bay Line Steamer
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County
(c) City or town Norfolk (If outside city or town limits, write RURAL and give town)
(d) Street No. 118 Virginia Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy Ann Pelot

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. WIDOW.

6 (b) Name of husband or wife IRVING PELOT

6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) JAN. 29, 1879

8. AGE: Years 68 | Months 8 | Days 10 | If less than one day ....hr. ....min.

9. Birthplace GEORGIA (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name UNKNOWN

13. Birthplace "

MOTHER 14. Maiden Name UNKNOWN

15. Birthplace "

16 (a) Informant WM E. PELOT

(b) Address 203 D. ST. GLENBURNIE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10 11 47 (month) (day) (year)

(c) Cemetery or crematory NORFOLK VA. CEM.

Location NORFOLK VA

18 (a) Funeral director JOHN F. DENNY, INC.

(b) Address 715 LIGHT ST. -30

19 (a) 9 AM (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/8/47 19.... at 5:45 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R Davis M.D. Medical Examiner.

Date signed 10/8/47

G55881

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

Registered No. G55881

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2312
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1507 S. Hanover Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES B. ADAMS

3 (b) If veteran, name war —

3 (c) Social Security Account No. 705-07-7934

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	MARRIED

6 (b) Name of husband or wife EMMA VIRGINIA ADAMS

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) DEC. 1, 1876

8. AGE: Years	Months	Days	If less than one day
70	10	6	____ hr. ____ min.

9. Birthplace JERSEY CITY, N.J.
(Town, county, and state)

10. Usual Occupation RAILROAD.

11. Industry or business

FATHER
12. Name JOHN WESLEY ADAMS
13. Birthplace BRISTOL, PENNA.

MOTHER
14. Maiden Name MARGARET M. MARSH
15. Birthplace PENNA.

16 (a) Informant MISS MARY A. ADAMS
(b) Address 1507 HANOVER ST.

17 (a) BURIAL (b) Date thereof 10 11 47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory PARKWOOD
Location TAYLOR AVE.

18 (a) Funeral director JOHN F DENNY, INC.
(b) Address 715 LIGHT ST -30

19 (a) OCT 9 1947 (b) Huntington for Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. (7) 8th 1947, at 5.25 P.M.

21. I certify that I took charge of the remains described above, held an insp. & inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions Diabetes

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl V. Ryan M.D.
Medical Examiner

Date signed 10-8-47

937

G55882

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G55882
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 6-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.OA.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 429- N. Durham Street.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MORGAN BREEDEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 61 | Months | Days | If less than one day hr. min.

9. Birthplace North Carolinia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace " "

MOTHER
14. Maiden Name Unknown
15. Birthplace " "

16 (a) Informant Nancy Breeden
(b) Address 429 N Durham St

17 (a) Burial (b) Date thereof Oct. 11. 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location Brooklyn, Md

18 (a) Funeral director Cloy O. Wilson
(b) Address 1000 Beanty ave

19 (a) (b)
(Date received by registrar) (Registrar)

OCT 9 1947

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8, 1947, at 11.40 P.M.

21. I certify that I took charge of the remains described above, held an insp & inq. thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions Emphysema of lungs
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Earl L Rose M.D.
Medical Examiner.

Date signed 10-8-47

G55883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46

G55883 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 20 NORTH PULASKI STREET
(c) Hospital or institution: **********
(d) Length of stay in hospital or inst. (yrs., mos., or days) ***
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY (If outside city or town limits, write RURAL and give town)
(d) Street No. 20 NORTH PULASKI STREET (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME: IDA W. PLITT

3 (b) If veteran, name war: *******
3 (c) Social Security Account No. *******

4. Sex: FEMALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: WIDOWED

6 (b) Name of husband or wife: FERDINAND G. PLITT
6 (c) If alive, give age D. years

7. Birth date of deceased (mo., day, yr.) 9/7/1870

8. AGE: Years 77 | Months 1- | Days -- | If less than one day ... hr. ... min.

9. Birthplace: BALTIMORE MARYLAND (Town, county, and state)
10. Usual Occupation: Housewife at
11. Industry or business: Home

FATHER
12. Name: Carl Stein
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Johanna Booze
15. Birthplace: Maryland

16 (a) Informant: Mrs. Paul W. Schoenfelder
(b) Address: 20 North Pulaski Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 10/47 (month) (day) (year)
(c) Cemetery or crematory: Western Cemetery
Location: Baltimore Maryland

18 (a) Funeral director: F.B. WIPPERT & SON
(b) Address: 1300 EUTAW PLACE...17

19 (a) 1947 (Date rec'd by registrar) (b) ... Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: OCTOBER 7th. 1947 at 12:45 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1935 to Oct. 7 1947 and that I last saw her alive on Oct 6 1947.

	Duration
Immediate cause of death: Chronic Myocarditis.	3 mo
Due to arteriosclerosis	1 year
Due to Carcinoma of Rectum	4 mo
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Clark Mortimer Pitt, M. D.
Address 2706 St. Paul Street Date signed 10/8/47

Sweet age is especially important. Physicians, please write

G55884 | BALTIMORE CITY HEALTH DEPARTMENT | G55884 Registered No.

CERTIFICATE OF DEATH 52B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 311 S. Highland a
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 311 S. Highland a (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Philbin

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Michael
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 9 1856
8. AGE: Years 91 | Months 6 7 | Days 39 | If less than one day hr. min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name John McGinnis
13. Birthplace Ireland.

MOTHER
14. Maiden Name Dont Know
15. Birthplace

16. (a) Informant Family (Next of kin)
(b) Address 311 S. Highland
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 10-47 (month) (day) (year)
(c) Cemetery or crematory New Cath. Location Old Frederick Rd.
18 (a) Funeral director John A. Mahan
(b) Address 700 E. Balto. St.
19 (a) (Date rec'd by registrar) (b) Registrar

OCT 9 1947 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7 1947, at 10 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 1947 to Oct 7 1947 and that I last saw her alive on Oct 7 1947.

	Duration
Immediate cause of death: Cerebral Hemorrhage	
Hypostatic pneumonia	1 day
Due to Debilitation —	
Carcinoma Bladder (?)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John M. Palese, M.D.
Address 11 E Chase St Date signed 10/9/47

correct age is especially important, physicians, please

X

055885 BCH D-89431

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. 055885

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2806 Harrison Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Michaelson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-19-47

8. AGE: Years | Months | Days: 2 | If less than one day: 2 hr. 21 min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jack Michaelson
13. Birthplace

MOTHER
14. Maiden Name Sylvia
15. Birthplace

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo SEP 22 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) 9 1947 (Date received by registrar) Washington Nitkiewicz M.D.

correct age is especially important. Physicians, please write plainly.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21 1947 at 11 1/2 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19 1947 to Sept 21 1947, and that I last saw living alive on Sept 21 1947.

Immediate cause of death	Duration
RESPIRATORY FAILURE	
ASPHYXIA NEONATORUM	
Due to ATELECTASIS	
Due to PREMATURITY	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. A. Spencer M.D.
Address Johns Hopkins Hospital Date signed 9/22/47
Harriet Lane Home

G55886 BALTIMORE CITY HEALTH DEPARTMENT G55886
Registered No.

CERTIFICATE OF DEATH 46E

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (~~yrs.~~ ~~mos.~~ or days) 29
(e) Length of stay in Baltimore (yrs., ~~mos.~~ or days) 68 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. St. Vincents Orphan (If rural give location)
(e) Citizen of foreign country? ~~Unknown~~, (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Muller

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ~~Unknown~~

8. AGE: Years 80? Months — Days — If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Laundress
11. Industry or business St. Vincents Orphan

FATHER
12. Name Bridget M. Kehoe
13. Birthplace Ireland

MOTHER
14. Maiden Name Patrick Mullins
15. Birthplace Ireland

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore City

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights Ave

19 (a) 10[illegible] (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8 1947 at 4:17 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 9 1947 to Oct. 8 1947 and that I last saw h~~e~~r alive on Oct. 6 1947.

Immediate cause of death	Duration
Carcinoma of Sigmoid	
Due to	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H.B. Scott M.D.
Address Mercy Hospital Date signed 10/8/47

VS 150

Please write the causes of death clearly and legibly. Physicians: please write as correct age is especially important.

G55887 BALTIMORE CITY HEALTH DEPARTMENT G55887
CERTIFICATE OF DEATH 46 B
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 17

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 18
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2739 Maryland Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William F. Yates

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Sarah Yates

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR. 30, 1883

8. AGE: Years	Months	Days	If less than one day
64	6	7	hr. min.

9. Birthplace Washington D.C. (Town, county, and state)
10. Usual Occupation unemployed
11. Industry or business

FATHER
12. Name Richard W. Yates
13. Birthplace Wash. D.C.

MOTHER
14. Maiden Name Mary Harper
15. Birthplace Wash. D.C.

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/10/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. City

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights

19 (a) 1947 (b) [illegible] rec'd by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7 1947 at 9:P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 8 1947 to Oct. 7 1947 and that I last saw h[illegible] alive on OCT. 7 1947

Immediate cause of death: Carcinoma of stomach — Duration

Due to

Due to

Other Conditions contributory cause
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D.L.B. Scott M.D. M.D.
Address Mercy Hospital Date signed 10/7/47

VS 150

Write plainly with pen or pencil. Do not use ditto marks. Be sure and answer all questions. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

G55888
CWK-114077

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 73a

G55888
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 704 Cathedral Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
William Proctor

3 (b) If veteran, name war: W. W. #1
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) ~~Single, married, widowed, or~~ divorced: Divorced Single
6 (b) Name of ~~husband or~~ wife: Callie Cattck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17-1889

8. AGE: Years 58 | Months 6 | Days 22 | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Printer
11. Industry or business No Record

FATHER
12. Name Richard Proctor
13. Birthplace North Carolina

MOTHER
14. Maiden Name Minnie Gardner
15. Birthplace North Carolina

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Removal (b) Date thereof 10/9/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Raleigh
Location North Caholina

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19. (c) 1947 [illegible] Williamsburg, Md. Registrar
(Date rec'd) (By)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9 1947, at 6:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 25 19 47 to Oct. 9 19 47 and that I last saw h im alive on Oct. 9 19 47

Immediate cause of death: Pernicious Anemia — Duration: 1 yr.
Due to
Due to
Other Conditions: Subacute Comb. Degenerat
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Raymond Beasley M.D.
Address Balto City Hosp. Date signed 9/25/47

Correct age is especially important. Physicians: please write plainly.

5889

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

Registered No. G55889

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner and Dukeland
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1724 No Payson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. ESTHER Glaser

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Agnate

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years: 75 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Joseph Russia
13. Birthplace

MOTHER
14. Maiden Name: Leah
15. Birthplace: Russia

16 (a) Informant: Markus Glaser
(b) Address: 1724 No Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-10-47 (month) (day) (year)

(c) Cemetery or crematory
Location: Nethgew Herring Run

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 2100 Eutaw Place

19 OCT 10 1947 (Date received by registrar) Huntington Williams M.D.

correct age is especially important. Physicians: please write clearly.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 Oct 1947, at 9:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 26 Sept 1947 to 9 Oct 1947, and that I last saw her alive on 9 Oct 1947.

	Duration
Immediate cause of death: Shock	4 hours
Due to: Intestinal Obstruction	1 day
Due to: Peritonitis	12 days
Due to: Ruptured Appendix	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation 26 Oct 47
Major findings of operation: Ruptured Appendix - Gangrenous Peritonitis
of autopsy: Hot Given

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: W Bell M.D.
Address: West Baltimore General Hospital Date signed 9 Oct 47 M. D.

55890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 54 B

G55890

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring Ave
(c) Hospital or institution:
Jewish Aged Home V
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. Greenspring Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MINNIE COHEN

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace Balto
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Jacob
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address

17 (a) Buried (b) Date thereof 10-12-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Washington D C
Location

18 (a) Funeral director Jack Levy Inc
(b) Address 2100 Eutaw Pl
OCT 10 1947
(Date rec'd by registrar) (b) Huntington Williams M

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-9 1947, at 9a M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-6 1947, to 10-9 1947
and that I last saw h. alive on 10-4 1947

Immediate cause of death Tumor of spinal cord — Duration over

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Henry Nagel M. D.
Address Lexington Ave Date signed 10-9-47

correct age is especially important. Physicians, please

VS 150

X

5891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G55891 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1016 N. Charles St. (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Yetta Brill

3 (b) If veteran, name war: —
3 (c) Social Security Account No.: —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) ? - ? - 1867
8. AGE: Years 80 | Months | Days | If less than one day ..... hr. ..... min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Abraham Stein
13. Birthplace Russia

MOTHER
14. Maiden Name Beile ?
15. Birthplace Russia

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 10/47 (month) (day) (year)
(c) Cemetery or crematory Mikro Kodesh
Location Bowleyline + Philadelphia Rd
18 (a) Funeral director Leo Levinson + Bros
(b) Address 174-26 W. North ave
19 (a) Oct 9 1947 (Date rec'd by registrar) (Huntington Williams, M.D. Registrar)

OCT 9 1947
OCT 10 1947

correct age is especially important. If uncertain, give approximate.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9 1947 at 11 10 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1947 to Oct. 9 1947 and that I last saw her alive on Oct 9 1947.

Immediate cause of death: Advanced Arteriosclerotic Heart Disease — Duration: —
Due to.....
Due to.....
Other Conditions Fracture of Left hip
(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 23/1
(a) Accident, suicide, or homicide? accident
(b) Date of occurrence 1 October 1947 M
(c) Where did injury occur? Balto, Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? yes (Specify type of place) While at work? no
(e) Means of injury? fall on floor
23. Signature Howard J. Moreton, M.D.
Address Johns Hopkins Hospital Date signed 10/9/47 M.D.

10/9/47

892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. 55892

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 11 S. Stricker St
(c) Hospital or institution:
19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 11 S. Stricker St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna May Dondera

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband ~~or wife~~ Late Philip Dondera

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 27 1878

8. AGE: Years 69 | Months 5 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Wm Ward

13. Birthplace Md

MOTHER 14. Maiden Name Laura Berenger

15. Birthplace Md

16 (a) Informant Mrs Young

(b) Address 11 S. Stricker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 11, 1947 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet

Location 2930 Frederick Ave

18 (a) Funeral director Harry A Welsh

(b) Address 401 Edmondson Ave

19 Oct 10 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

correct age is especially important. Physicians: please write plainly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 7, 1947 to Oct 8 1947 and that I last saw h[illegible] alive on Oct 8 1947

Immediate cause of death	Duration
Ca of Breast	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Milton Lisanick M.D.

Address 1729 W Fayette Date signed 10/11/47

5893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

125 B

Registered No. C55893

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edward + Freret St.
(c) Hospital or institution: University Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1521 N. Carey St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elvira Keyes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years: 60 | Months | Days | If less than one day: hr. min.

9. Birthplace Staunton Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John W. Keyes
13. Birthplace Albert Co Md

MOTHER
14. Maiden Name Elvira Brown
15. Birthplace Staunton Va

16 (a) Informant Mable Wiggins
(b) Address 1521 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 13-1947 (month) (day) (year)
(c) Cemetery or crematory Arbutus M. Park
Location Arbutus

18 (a) Funeral director Va Brooks
(b) Address 1463 N. Carey St

19 (a) Oct 10 1947 (Date received by registrar) (b) Kathryn Williams M.D.

VS-150

correct age is especially important. Physicians: please write

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8 1947, at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1947, to Oct 8 1947, and that I last saw h[illegible] alive on Sept 8 1947.

	Duration
Immediate cause of death Cerebral Hemorrhage	
Due to Hypertension Insufficiency	
Due to	
Other Conditions Uremia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Dent.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Audrey H. Hacks M. D.

Address Univ. Hosp. Date signed 10-7-47

X

5894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G55894

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2907 Riggs Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 88 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2907 Riggs Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kate G. Weikel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife William Weikel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 10 1859

8. AGE: Years	Months	Days	If less than one day
88	6	30	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name ------ Wackenhager
15. Birthplace Unknown

16 (a) Informant Florence S. Weikel
(b) Address 2907 Riggs Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 13 1937 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Harry Abercrombie
(b) Address 4204 Ridgewood Ave

OCT 10 1937 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 9th 1937, at 10 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21st 1937 to Oct 9 1937 and that I last saw her alive on Oct 9 1937.

Immediate cause of death	Duration
Cerebral Hemorrhage	3
Due to Cardio-Vascular.	20 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Joseph Zigler M. D.
Address 2318 Eutaw Place Date signed Oct 9/37

correct age is especially important. Physicians, please

VS 150

5895 114326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 B

Registered No. 655895

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 71
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2003 Ashland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Dunn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30 ~~May 28~~ 1888

8. AGE: Years 59 Months 2 Days 9 If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B.C.H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 10/10/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Matthews
Location Old Pomeroy St.

18 (a) Funeral director Lilly & Zeh
(b) Address 403 S. Wolfe St.

19 (a) OCT 9 1947 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8 1947, at 11:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-7 1947 to 10-8 1947 and that I last saw him alive on Oct. 8- 1947

Immediate cause of death Pulmonary Edema — Duration 3 weeks

Due to Cardiac insufficiency — 6 mos.

Due to Arteriosclerotic C.V.D. — 7 yrs.

Other Conditions Cirrhosis of liver, Cause undet; Gast. Carcinoma.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lawrence Lee Jr. M. D.
Address Baltimore City Hosps Date signed 10-9-47

correct age is especially important. Physicians: please write the cause of death plainly.

VS 150

937

896

BC# 891929

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157c

G55896 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W Fayette St
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 627 St. Dunstans Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JANIS LEE BERLINICKE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 9. 1947

8. AGE: Years	Months	Days	If less than one day
			16 hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Monk J Berlinicke
13. Birthplace Balt Md

MOTHER
14. Maiden Name Gwendolyn L Nunnally
15. Birthplace Baltimore Md

16 (a) Informant Monk J Berlinicke
Address 627 St Dunstans Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-11-47 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem
Location Baltimore Md

18 (a) Funeral director Wilson & Dove
(b) Address 3170 Cont Ave

19 (a) Oct 10 1947 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-9 1947 at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-9 1947 to 10-9 1947 and that I last saw h.r. alive on 10-9 1947

Immediate cause of death Asphyxia — Duration

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury Obstruction

23. Signature — M. D.
Address Bon Secours Hosp Date signed 10-9-47

PLEASE WRITE PLAINLY. Fill in all blanks. Be sure to give the causes of death clearly and correctly. Be sure correct age is especially important. Physicians: please write the cause of death clearly and legibly.

5897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G55897

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1001 St. Paul St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mary Goldthwaite

3 (b) If veteran, name war /
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/21/87

8. AGE: Years	Months	Days	If less than one day
59	11	17	hr. min.

9. Birthplace Indiana (Town, county, and state)
10. Usual Occupation Tech. nurse
11. Industry or business Johns Hopkins Hospital

FATHER
12. Name Edgar H. Goldthwaite
13. Birthplace Ind

MOTHER
14. Maiden Name Candace Zambri
15. Birthplace Ohio

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Cremation (b) Date thereof 10/10/47 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul st.

19 OCT 10 1947 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

VS 150

correct age is especially important. Physicians: please write plainly.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/8 1947, at 10:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/22 1947, to 10/8 1947, and that I last saw h[illegible] alive on 10/8 1947.

Immediate cause of death	Duration
Primary Carcinoma of lung with widespread metastases	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address Johns Hopkins Hosp. Date signed 10-9-47

5898 Med. Examiner case

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1864

Registered No. 055898

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Ave.
(c) Hospital or institution: Maryland Gen'l Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Alice Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Wh

6 (a) ~~Single, married~~, widowed, or ~~divorced~~ Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 20 Nov. 1861

8. AGE: Years 85 | Months 10 | Days 14 | If less than one day ..... hr. ..... min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Samuel Pence
13. Birthplace Va.

MOTHER
14. Maiden Name Rebecca (Unknown)
15. Birthplace "

16 (a) Informant Alice A. Brown
(b) Address 1708 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/10/47 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

OCT 10 1947
(a) (Date rec'd by registrar) Director for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 Oct. 1947, at 12 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5 Aug. 1947, to 9 Oct. 1947, and that I last saw her alive on 9 Oct. 1947

Immediate cause of death	Duration
Pulmonary embolism	
Due to Cardiac decompensation	
Due to	
Other Conditions Fracture R. hip	5 Aug 1947

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 14/2
(a) Accident, ~~suicide, or homicide~~ Accident
(b) Date of occurrence 5 Aug 1947 at M
(c) Where did injury occur? Baltimore Md.
(City or town) (County) (State)
(d) Did injury occur about home, ~~on farm, industrial place, or public place~~? Nursing Home While at work? No
(Specify type of place)
(e) Means of injury Fell on steps
23. Signature M.T. McLogan
Address Md. Gen. Hospital Date signed 9 Oct. (M. D.) 1947
Howard J. Mendelsohn, M.D.

X

correct age is especially important. Physicians: please write the causes of death clearly and fully.

55899 BALTIMORE CITY HEALTH DEPARTMENT G55899

CERTIFICATE OF DEATH 170c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Md. School for Blind (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William J. Boyd Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of ~~husband~~ or wife Lucy Mildred Boyd

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 10th 1885

8. AGE: Years 62 | Months 0 | Days 29 | If less than one day ____hr. ____min.

9. Birthplace Charlottesville N.C. (Town, county, and state)

10. Usual Occupation Caretaker

11. Industry or business Md School for Blind

FATHER
12. Name William Boyd
13. Birthplace Caddett Va.

MOTHER
14. Maiden Name Catherine (Mckenzie)
15. Birthplace Va

16 (a) Informant ~~Mrs~~ Catherine Boyd
(b) Address 1212 St. Paul St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 10/11/47 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

19 (Date rec'd by Registrar) OCT 10 1947 Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION 45

20. DATE OF DEATH 10-8- 1947 at 10 A.M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull & Intracranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 27/5
(a) Date of injury 10/8/47 at 10 A.M.
(b) Where did injury occur? Md. School for Blind
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? YES
(d) Means of injury Fell off truck

23. Signature Earl L. Royer M.D. Medical Examiner.
Date signed 12-8-47

655900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47a

Registered No. 655900

PLEASE WRITE PLAINLY, with ink. Use no abbreviations. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 809 Stiles St. (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Domenico Mascilli

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife FILOMENA

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 5, 1895

8. AGE: Years	Months	Days	If less than one day
52 yr	2	3	hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Stone Mason

11. Industry or business

FATHER
12. Name Ralph Mascilli
13. Birthplace

MOTHER
14. Maiden Name Domenica Carlo
15. Birthplace

16 (a) Informant Sam Cialini
(b) Address 809 Stiles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 11-47 (month) (day) (year)
(c) Cemetery Holy Redeemer
Location Belair Rd Baltimore Md

18 (a) Funeral director Frank Della Luca
(b) Address 52 N. Hanover St.

19 OCT 10 1947 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8 1947, at 10 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8 30 a.m., 10/8 1947, to 10/8 1947, and that I last saw him alive on 9 30 a.m., 10/8 1947.

Immediate cause of death Respiratory failure — Duration

Due to Obstruction by Ca of larynx

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Tracheotomy

Major findings of operation: Ca of larynx

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank A. Sasse M.D.

Address Mercy Hosp Date signed 10/10/47

X

55901

BALTIMORE CITY HEALTH DEPARTMENT ✓ G55901
CERTIFICATE OF DEATH 131a
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3118 Kaminwood Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3118 Kaminwood Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Heilmann Cecelia M.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Charles C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 8-1891

8. AGE: Years 56 | Months 11 | Days 29 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Jacob Dieter

13. Birthplace 3007 Belair Rd

MOTHER 14. Maiden Name Margaret Kraemer

15. Birthplace Balto

16 (a) Informant Mr Jacob Dieter

(b) Address 3007 Belair Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 11-47 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balto

18 (a) Funeral director J. Slater & Son

(b) Address 3091 Kentucky Ave

OCT 10 1947 (Date rec'd by registrar) Attending for Nellie Smyth M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-7- 1947, at 4:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-27- 1943 to 8-21- 1947 and that I last saw her alive on 8-21- 1947.

Immediate cause of death	Duration
Acute dilatation of heart	30 min.
Due to Cardio-vascular-renal disease	1943
Due to Generalized arteriosclerosis	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton C. Craig M. D.

Address 2117 Belair Rd Date signed 10-7-47

VS 150

X

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

5902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13/a

Registered No. G55902

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2644 Maryland avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2644 Maryland ave. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ANN SHEEHAN

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: Female

5. Color or race: white

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Dennis Sheehan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19- 1862

8. AGE: Years 84 | Months 11 | Days 21 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name John Dougherty
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Burns
15. Birthplace Ireland

16 (a) Informant Miss Gertrude Sheehan
(b) Address 2644 Maryland avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Evans & Sons
(b) Address 118 N. Mt. Royal Ave

19 (a) OCT 10 1947 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 12 1947 to Oct 9 1947 and that I last saw h[illegible] alive on Oct 9th 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension	15 yrs
Due to Chronic Interstitial Nephritis	Same
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George W. Gibbons M. D.
Address 28 W 26th St. Date signed 10-10-47

X

5903

BALTIMORE CITY HEALTH DEPARTMENT ✓ Registered No. 655903

CERTIFICATE OF DEATH 137a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore - 11
(If outside city or town limits, write RURAL and give town)
(d) Street No. 446 Fawcett St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nicolo Esposito

3 (b) If veteran, name war None | 3 (c) Social Security Account No. 218-10-7731

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Catherine
6 (c) If alive give age ? years

7. Birth date of deceased (mo., day, yr.) 8 Dec 1883

8. AGE: Years	Months	Days	If less than one day
63	10 9	9	hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Rocco Esposito
13. Birthplace Italy

MOTHER 14. Maiden Name Raffaela —
15. Birthplace Italy

16 (a) Informant Catherine Esposito
(b) Address 446 Fawcett St

17 (a) Burial (b) Date thereof Oct 13-1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Batts Md
Location

18 (a) Funeral director Edward Taulson
(b) Address 357 Washington Blvd

19 OCT 10 1947 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 Oct 1947 at 8:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 22 Sept 1947 to 9 Oct 1947 and that I last saw h[illegible] alive on 9 Oct 1947.

Immediate cause of death	Duration
shock	
Due to hemorrhage	
Due to operation on prostate gland	
Other Conditions nephritis - acute. Sept 46	

(Include pregnancy within 3 months of death)

Date of operation October 7, 1947
Major findings of operation: Hemorrhage from prostate gland
of autopsy: None performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) ~~Accident, suicide, or homicide~~
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Irving Sckerlis
Address Sinai Hospital Date signed 7 Oct 47

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G55904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

65a

G55904
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1530 Mc Elderry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Godlock

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1893

8. AGE: Years	Months	Days	If less than one day
55	4		hr. min.

9. Birthplace Gaffney Ga.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Andrew Hombrick
13. Birthplace N.C.

MOTHER
14. Maiden Name Sallie Hoggins
15. Birthplace N.C.

16 (a) Informant Gertrude Reynolds
(b) Address 1530 McElderry St

17 (a) Burial (b) Date thereof Oct 10 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Gaffney S.C.
Location South Carolina

18 (a) Funeral director Robert F. Williams
(b) Address 1545 McElderry St
Huntington Williams, Md.

19 (a) (b)
(Date rec'd by registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-8-1947 at 1:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardiac disease.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mesdeis M.D.
Medical Examiner.
Date signed 10-8-47

X

G55905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

G55905 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1552 N. Carey St
(c) Hospital or institution: 151
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1552 N. Carey St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lou Cottman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or wife Annie Cottman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 18, 1881

8. AGE: Years	Months	Days	If less than one day
67	1	23	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name Jeffery Cottman
13. Birthplace Va

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Ophila Jones
(b) Address 1552 N. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/47 (month) (day) (year)
(c) Cemetery or crematory Lancaster Co. Va.
Location Lancaster Co. Va.

18 (a) Funeral director Geo. H. Nelson
(b) Address 1303 Pennsylvania Ave.

19 (a) [illegible] 10 1947 (b) [illegible] Washington Williams Co. Coroner
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 10 1947, at 1:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 6 1947, to Oct 10 1947, and that I last saw h[illegible] alive on Oct 10 1947.

Immediate cause of death: pulmonary hemorrhage — Duration 20 min.
Due to Carcinoma of prostate with metastases — 4 mos.
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —
23. Signature James L. Carr M. D.
Address 515 Mosher St Date signed 10.10.47

PLEASE WRITE LEGIBLY. Physicians: please write the causes of death clearly and correct age is especially important.

VS 150

G55906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

G55906 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2323 Harlem Ave
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2323 Harlem Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY A. REYNOLDS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Annie Cecelia Duff
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/21/67

8. AGE: Years	Months	Days	If less than one day
80	1	18	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation At Home (retired)

11. Industry or business

FATHER
12. Name Joseph Reynolds
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth A. Redden
15. Birthplace Maryland

16 (a) Informant Miss Alice Virginia Reynolds
(b) Address 2323 Harlem Ave

17 (a) Burial (b) Date thereof 10/13/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director D. H. Means and Son
(b) Address 845 N. Calvert St.

19 (c) [illegible] by registrar Huntington Williams M.D.

OCT 19 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 9 1947, at 3:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944 to Oct 9 1947, and that I last saw h. l. alive on Oct 9 1947.

Immediate cause of death Carcinoma of Prostate — Duration 1 yr

Due to

Due to

Other Conditions Arteris - sclerotic Heart disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. M. Collins M. D.
Address 332 Frederick Ave Date signed 10-10-47

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and correct age is especially important.

G55907 BALTIMORE CITY HEALTH DEPARTMENT ✓ G55907
Registered No.

CERTIFICATE OF DEATH 48a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1715 E. Federal St
(c) Hospital or institution:
8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1715 E. Federal St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine Finck

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: William Finck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 1 1873

8. AGE: Years 73 | Months 10 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation House work
11. Industry or business at Home

FATHER
12. Name Mathais Hammel
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Hunsickheimer SMITH
15. Birthplace Germany

16 (a) Informant Mrs. Madeline F. Smith
(b) Address 1715 E. Federal St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 11, 1947 (month) (day) (year)
(c) Cemetery or crematory Emmanuel Cem. Location Gorsuch Ave near Harford Rd

18 (a) Funeral director Elmer H. Conflenser Son
(b) Address 9249 Eager St.

19 (a) (Date rec'd by Registrar) (b) Huntington Wills Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8, 1947 at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 31 47 to Oct. 8, 1947. and that I last saw her alive on Oct. 8, 1947.

Immediate cause of death	Duration
General Carcinomatous Metastases	2 Mos.
Due to Carcinoma of the cervix & Uterine appendages.	7 Mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edwin Baumgardt M. D.
Address 1613 E. North Ave. Date signed 10-9-47.

correct age is especially important. Physicians: please write the causes of death clearly.

G55908 BALTIMORE CITY HEALTH DEPARTMENT ✓G55908
CERTIFICATE OF DEATH 52B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1714 E Monument St
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2407 Eldinor Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Ernest Saunders

3 (b) If veteran, name war | 3 (c) Social Security Account No. 439-10-6967

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Lilah Saunders

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8 1882

8. AGE: Years 65 | Months 4 | Days | If less than one day hr. min.

9. Birthplace Louisiana (Town, county, and state)

10. Usual Occupation Manager

11. Industry or business Dept. store

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden Name "

15. Birthplace "

16 (a) Informant Hiram Raleigh Cannon Jr

(b) Address 2407 Eldinor Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-47 (month) (day) (year)

(c) Cemetery or crematory Greenwood Cem

Location New Orleans

18 (a) Funeral director John C Miller Inc

(b) Address 243 E Lafayette Ave

19 (a) (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8 1947, at 8:24 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/20 1947 to 10/8 1947, and that I last saw him alive on 10/8 1947.

Immediate cause of death: Carcinoma of bladder, Peritonitis, mesenteric — Duration

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: Carcinoma of bladder

of autopsy: Carcinoma of bladder peritonitis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature Norman E Zumbrun M. D.

Address Linwood Date signed 10/13/47

Please write plainly. Physicians: please write correct age is especially important.

150

X

G55909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

G55909
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2707 Manhattan Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2707 Manhattan Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME OSCAR McCAULEY FRANTZ

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Marguerite Frantz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 20, 1869

8. AGE: Years	Months	Days	If less than one day
78	5	18	hr. min.

9. Birthplace Salem, Virginia
(Town, county, and state)
10. Usual Occupation Clerical Work
11. Industry or business Md. Casualty

FATHER
12. Name Marshall P. Frantz
13. Birthplace Virginia

MOTHER
14. Maiden Name Virginia McCauley
15. Birthplace Virginia

16 (a) Informant Mr. John E. Frantz
(b) Address 2707 Manhattan Ave.

17 (a) Burial (b) Date thereof 10/11/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cema.
Location Pikesville, Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 10 1947 (b)
(Registrar) Huntington Williams, M.D.

VS 150

PLEASE WRITE PLAINLY. Physicians: please write the causes of death in such terms as will indicate the correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8, 1947, at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 30 1947 to Oct 8 1947 and that I last saw him alive on Oct 8 1947

Immediate cause of death	Duration
Chronic Valvular Heart Disease	3 years
Due to Pulmonary oedema	11 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. William Frey, M.D.
Address 928 Penna Ave. Date signed 10/9/47

X

G55910 BC# G-65901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G55910
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dayson & Fayette Sts.
(c) Hospital or institution: Bon Secour Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1635 Thomas St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Diane Hinton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 18, 1946

8. AGE: Years | Months: 9 | Days: 21 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Joseph T. Hinton, Jr.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Ruth J. Dittman
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Joseph T. Hinton, Jr.
(b) Address 1635 Thomas Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 11 47 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave

18 (a) Funeral director John Lawrence Sons
(b) Address 1103 Gallows St.

19 (a) (Date received by local registrar) 1947 (b) Huntington Williams Registrar

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/9/1947 at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 18 1947 to Oct 9 1947 and that I last saw her alive on Oct 9, 1947.

Immediate cause of death	Duration
Bronchial pneumonia	3 days
Due to acute respiratory infection	3 wks
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George A. Kemp M. D.
Address 3030 Edmondson Ave Date signed 11/10/47

PLEASE WRITE PLAINLY. Physicians: please write the cause of death clearly and report correct age is especially important.

G55911 ✓ G55911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. [illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2818 Ashland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret A. Snyder

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Donald

6 (c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): 7-9-06

8. AGE: Years: 41 | Months: 2 | Days: 29 | If less than one day: hr. min.

9. Birthplace: Pa (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER — 12. Name: Wm. Davis
13. Birthplace: Pa

MOTHER — 14. Maiden Name: Maude Bishop
15. Birthplace: Pa

16 (a) Informant: Records
(b) Address: [illegible]

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/47 (month) (day) (year)
(c) Cemetery or crematory: Baltimore
Location: North Ave. & Rose St. Balto. Md.

18 (a) Funeral director: Charles E. Schimunek
(b) Address: 2601-3-5 E. Madison Street

19 (a) 10/10/47 (Date rec'd by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8, 1947, at 1 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 22 1947 to Oct 8 1947 and that I last saw her alive on Oct 8 1947

Immediate cause of death	Duration
a Renal failure	24 hours
Due to Secondary Carcinoma	
Due to Carcinoma of Pelvis	
Other Conditions Bilateral Renal Stones	

(Include pregnancy within 3 months of death)

Date of operation July 1946
Major findings of autopsy: Secondary carcinoma - Pelvis - Liver
of autopsy: Kidneys - abdomen

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard John Quigley M.D.
Address 600 N. Broadway Date signed 10-2-47

correct age is especially important. Physicians: please write the cause of death plainly.

G55912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 055812

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Josephs Hospital
(c) Hospital or institution: 1400 N. Caroline St.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3312 Ailsa ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph P. Murphy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M.

6 (b) Name of husband or wife Gertrude V.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-27-1891

8. AGE: Years	Months	Days	If less than one day
56	0	12	hr. min.

9. Birthplace Mass.
(Town, county, and state)

10. Usual Occupation Engineer -
11. Industry or business Maryland Drydock.

FATHER
12. Name Patrick Murphy
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Collins
15. Birthplace Ireland

16. (a) Informant Gertrude V. Murphy
(b) Address 3312 Ailsa ave.

17 (a) Burial (b) Date thereof 10/13/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rood Cem
Location Brookline - Mass.

18 (a) Funeral director Leonard J. Buck
(b) Address 5305 Harford Rd.

19 Oct 10 1947 (b)
(Date rec'd by registrar) Registrar

VS 150 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-9 1947, at 5:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-7 1947 to 10-9 1947 and that I last saw him alive on 10-9 1947

Immediate cause of death Coronary Thrombosis

Due to Arteriosclerotic heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E May M. D.
Address St Josephs Hosp Date signed 10-9-47

PLEASE WRITE PLAINLY. Please write the cause of death clearly and accurately. Physicians: please write correct age is especially important.

G55913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

Registered No. G55913

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 704 N. Fort Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MRS ELIZABETH HIGHLAND

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Elmer Highland
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation at Home
11. Industry or business

FATHER
12. Name George L. Campbell
13. Birthplace

MOTHER
14. Maiden Name Henrietta Shroud
15. Birthplace

16 (a) Informant Mrs. L. Philip Arnold
(b) Address 2901 Hamilton Ave

17 (a) Burial (b) Date thereof 10/13/47 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto

18 (a) Funeral director Leonard J. Luck
(b) Address 5305 Harford Rd.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 10, 1947, at 12 49 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10, 1947, to Oct 10 1947 and that I last saw h[illegible] alive on Oct 10 1947

Immediate cause of death	Duration
Intracerebral Hemorrhage and Subarachnoid hemorrhage	
Due to Generalized Arterio - Sclerosis +	
Due to Essential Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Allan J. Wolinsky M. D.
Address Sinai Hospital Date signed Oct 10, 1947

Please write plainly. Physicians: please write the correct age is especially important.

G55914 — C.M. 118173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124a

Registered No. G55913

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 916 E. Pratt ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Cornelius

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May - 11 -1897

8. AGE: Years	Months	Days	If less than one day
50	4	24	hr. min.

9. Birthplace Montanna
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Lewis Cornelious
13. Birthplace Montanne

MOTHER
14. Maiden Name Eleanor Vear
15. Birthplace Montanna

16 (a) Informant Records B.lto. City Hospitals
(b) Address 4940 Eastern AVE.

17 (a) Burial (b) Date thereof 10/10/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Herman Stone Road

18 (a) Funeral director J. J. Fahey Sons
(b) Address 1518 Light St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4 - 1947, 11.15P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 30 19 47 to Oct. 4- 19 47, and that I last saw her alive on Oct. 4 - 19 47.

Immediate cause of death	Duration
Asthenia of Liver	
Due to Chronic ulceration	
Due to	
Other Conditions Hypertensive cardiovascular disease	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. T. Binford M. D.
Address Balt. City Hosp. Date signed 10-9-47

Please write the causes of death clearly and correct age is especially important. Physicians: please write

G55915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G55915

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1330 W. Lombard St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 70
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3166 Wilkens Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert A. Rawming

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Late Madeline Laib Rawming
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1892

8. AGE: Years 55 | Months 2 | Days | If less than one day: hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Book binder
11. Industry or business Faulkner & Co.

FATHER
12. Name Adam Rawming
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Charlotte Renesser
(b) Address 1330 W. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 13/47. (month) (day) (year)
(c) Cemetery or crematory Louden Park
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Lubke
(b) Address 4101 Edmondson Ave.

19 (a) 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9/47 19 , at 4.00 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 13, 1944 to Oct 9, 1947, and that I last saw him alive on Sept 6, 1947.

Immediate cause of death: Acute coronary occlusion — Duration: 3 hours
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Yaffe M.D.
Address 3101 W. Baltimore St. Date signed 10/9/47 M. D.

VS 150

PLEASE WRITE PLAINLY. Please write the causes of death clearly and correct age is especially important. Physicians: please write

BC# G55916 b 73036

BALTIMORE CITY HEALTH DEPARTMENT ✓ G55916

CERTIFICATE OF DEATH 119a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1622 W. Fayette St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1622 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Camelia Lee Gilley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5, 1947

8. AGE: Years	Months	Days	If less than one day
	7	5	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name George Gilley
13. Birthplace Md.

MOTHER
14. Maiden Name Agnes Stewbridge
15. Birthplace Tenn.

16 (a) Informant Mrs. Agnes Gilley
(b) Address 1622 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 13/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd

18 (a) Funeral director Harry H. Tuttle
(b) Address 4101 Edmondson Ave.

19 (a) OCT 10 1947 (b) Registrar Williams, M.D.
(Filed record by registrar) Registrar

VS 150

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10/47; 19 ; at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 9 1947 to Oct 10 1947 and that I last saw h[illegible] alive on Oct 9 1947

Immediate cause of death Bronchopneumonia — Duration
Due to Diarrhoea
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mattie Fitzgerald M. D.
Address 1629 W Fayette St Date signed 10/13/47.

X

G55917 G55917

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use typewriter if possible. Do not write the causes of death clearly and legibly. correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 33 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2001 Park Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sallie Ann Willson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	Widowed

6 (b) Name of husband or wife Wm. E. Bartlett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1855

8. AGE: Years	Months	Days	If less than one day
92	7	3	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name John Milton Bartlett
13. Birthplace Maryland

MOTHER
14. Maiden Name Sallie Ann Turner
15. Birthplace Pennsylvania

16 (a) Informant hospital records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/47 (month) (day) (year)
(c) Cemetery or crematory Friends Burial Grnds
Location Easton, Md.

18 (a) Funeral director L. Vernon Kenworthy
(b) Address 4611 Park Heights

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9 1947, at 11:58 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 6 1947 to Oct 9 1947 and that I last saw h[illegible] alive on Oct 9 1947

Immediate cause of death Cerebro-vascular accident — Duration 3 mos.
Due to Old age
Due to
Other Conditions Fractured left femur — 5 wks
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 13/2
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Sept. 5, 1947 at 8 P M
(c) Where did injury occur? Baltimore, Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? [illegible]
(Specify type of place)
(e) Means of injury Fractured femur caused by turning heel.

23. Signature D. Otis Montgomery M.D.
Address Mercy Hospital Date signed 10/9/47

Howard J. Thomsen, M.D.

VS 150

G55918 DC4 G86501

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 157E

Registered No. G55918

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. CAROLINE ST
(c) Hospital or institution: ST. JOSEPH'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 46 days
(e) Length of stay in Baltimore (yrs., mos., or days) 53 days

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE, MD (If outside city or town limits, write RURAL and give town)
(d) Street No. 2022 E. CHASE ST (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ANTHONY COMEGNA

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/17/47

8. AGE: Years | Months 1 | Days 53 | If less than one day hr. min.

9. Birthplace BALTIMORE - MD. (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER 12. Name HORACE ARCHIE COMEGNA

13. Birthplace BALTIMORE, MD.

MOTHER 14. Maiden Name MARGARET SIDDLEMEYER

15. Birthplace BALTIMORE MD.

16 (a) Informant HORACE A. COMEGNA

(b) Address 2022 E CHASE ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10/11/47 (month) (day) (year)

(c) Cemetery or crematory ST. VINCENT'S

Location CLIFTON PARK BALTO.

18 (a) Funeral director Charles E. Schmunk

(b) Address 2601 E. Madison, St

19 (a) (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

OCT 20 1947

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/9 1947, at 4 30 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 8/24 1947 to 10/9 1947, and that I last saw him alive on 10/9 1947.

Immediate cause of death — Duration

CONGENITAL HEART — BIRTH

Due to DISEASE

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Henry J. Houska M. D.

Address 600 N. Wolfe Date signed 10/9/47

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and legibly. Omit words like "chronic" or "old age." Please write correct age in years, months, days. Do not abbreviate. Be sure that every question is answered. Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Omit words like "chronic" or "old age." Please write correct age is especially important.

G55919

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G55919

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 103 E. 22nd Street
(c) Hospital or institution:
Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) -
(e) Length of stay in Baltimore (yrs., mos., or days) -

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 103 E. 22nd Street
(If rural give location)
(e) Citizen of foreign country? - (Yes or No)
If yes, name country -

3 (a) FULL NAME Thomas Heux Benson Dunn

3 (b) If veteran, name war: no

3 (c) Social Security Account No. -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary C. Dunn
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Dec. 8, 1871

8. AGE: Years	Months	Days	If less than one day
75	10	1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Attorney - U.S. Govt.
11. Industry or business Retired

FATHER
12. Name Andrew Dunn
13. Birthplace Ireland

MOTHER
14. Maiden Name Cornelia Cummings
15. Birthplace Baltimore

16 (a) Informant Mrs. Mary Dunn
(b) Address 103 E. 22nd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Octo 13. 1947 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Loudon Park

18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul Street

OCT 11 1947 (Date received by registrar) (b) Huntington Hillsboro, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9 1947, at 7:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/9 1947 to 10/9 1947 and that I last saw h alive on 19

Immediate cause of death	Duration
Coronary Occlusion	3 Hrs.
Due to Arteriosclerosis	
Due to Arteriosclerosis	
Other Conditions Bronchitis	2 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edwin H. Hall M.D.
Address 2020 N. Charles Date signed 10/10/47

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and accurately. Exact age is especially important.

C55920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. C55920

PLEASE WRITE PLAINLY. Use ink. Do not use pencil. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 W. Lexington St.
(c) Hospital or institution: Aged Women's + Aged Men's Homes
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ida K. Van Saint

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 9 - 1864

8. AGE: Years 82 | Months 8 | Days 1 | If less than one day ..... hr. ..... min.

9. Birthplace Unknown (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas H. Van Saint
13. Birthplace Unknown

MOTHER
14. Maiden Name Catherine Horiser
15. Birthplace

16 (a) Informant (Mrs) L. H. Read Supt.
(b) Address 1400 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/47 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

OCT 15 1947

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 1947, at 11:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1947 to October 8 1947 and that I last saw h[illegible] alive on October 8 1947

Immediate cause of death Cardio respiratory failure — Duration: 1

Due to Pan Cerebral hemorrhage

Due to generalized atherosclerosis

Other Conditions Carcinoma left breast - possible metastasis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Maryland Edward Day M.D.

Address 4-E-33rd St - 18 Date signed 10-13-47

X

G55921

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 160 C

G55921
Registered No.

PLEASE WRITE PLAINLY; write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: ~~Bay View~~ East Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Glenarm (If outside city or town limits, write RURAL and give town)
(d) Street No. Glenarm Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Daniel Robert Burton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1947

8. AGE: Years | Months | Days: 24 | If less than one day: hr. min.

9. Birthplace Balto. Co., Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John H. Burton
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden Name Leila I. Grover
15. Birthplace Balto. Co., Md.

16 (a) Informant Mrs. John H. Burton
(b) Address Glenarm, Md.

17 (a) burial (b) Date thereof Oct. 11, 1947 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Waugh Chapel
Location Glenarm, Md.

18 (a) Funeral director Lowe's Funeral Home
(b) Address 7401 Belair Road

19 (a) [illegible] (b) [illegible] Registrar
(Date received by registrar)

OCT 12 1947

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 9 1947 at 6 00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 9 1947 to Oct 9 1947 and that I last saw him alive on Oct 9 1947

	Duration
Immediate cause of death Respiratory arrest.	
Due to Meningitis-pneumococcal	
Due to	
Other Conditions Haemorrhage-r kidney Cephalgia haematuria	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Meningitis-pn.; haemorrhage r kidney, cephalgia haematuria

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury Howard Lasker

23. Signature

Address West Balt Genl Hosp Date signed 10/10/47 M. D.

G55922 BC# D91035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

G55922
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Balto City Md.
(c) Hospital or institution:
Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto. Overlea
(If outside city or town limits, write RURAL and give town)
(d) Street No. 201 Henry Ave.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BABY KLEIN (Bernard C. Klein)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10th 1947

8. AGE: Years	Months	Days	If less than one day
			10 hr. 5 min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Geo. A. Klein Jr.
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Elizabeth V. Knell
15. Birthplace Balto. City Md.

16 (a) Informant Geo. A. Klein Jr.
(b) Address 201 Henry Ave.

17 (a) Burial (b) Date thereof Oct. 11th 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Md.

18 (a) Funeral director Langahan Funeral Home
(b) Address 7401 Belair Rd.

19 (a) [illegible] Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/10/1947, at 4:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/10/1947 to 10/10/1947, and that I last saw him alive on 10/10/1947.

Immediate cause of death Subarachnoid hemorrhage

Due to Tentorial tear

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address Sinai Hosp Date signed 10/10/47

PLEASE WRITE PLAINLY with pencil or pen. Physicians: please write the causes of death clearly and supply correct age is especially important.

G55923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G55923 ✓ Registered No. 1

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 133 W. Clement St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME FREDERICK G. DUDECK

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Emma K. Dudeck
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1893

8. AGE: Years	Months	Days	If less than one day
54		29	..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Burner and Welder
11. Industry or business Maryland Dry Dock

FATHER
12. Name ——— Dudeck
13. Birthplace Unknown

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Emma K. Dudeck
(b) Address 133 W. Clement Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 13 1947 (month) (day) (year)
(c) Cemetery or crematory Lodge Hill
Location [illegible]

18 (a) Funeral director A. Edward Evans
(b) Address 1400 Eutaw St

OCT 11 1947 (Date rec'd by registrar) (b) ..... Registrar

Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10, 1947, at 8.15 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 10-10-47

X

Correct age is especially important. [illegible]

655924 DC# 590519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

✓ 655924 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1d
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1719 Harford ave (If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Baby A. Miles

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 10-3-47

8. AGE: Years — | Months — | Days 1 | If less than one day ... hr. ... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation.....

11. Industry or business.....

FATHER
12. Name ?
13. Birthplace.....

MOTHER
14. Maiden Name Minnie Miles
15. Birthplace ?

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a)..... (Burial, cremation, or removal) (b) Date thereof..... (month) (day) (year)
(c) Cemetery or crematory.....
Location Johns Hopkins Medical Schoo OCT 7, 1947

18 (a) Funeral director Commissioner of Health
(b) Address.....

OCT 11 1947 Hilleary for Williams M.D.
(Date rec'd by Registrar)

VS 150

PLEASE WRITE PLAINLY, with ink. Do not use pencil. Do not abbreviate. Be sure to write the causes of death clearly and legibly. Give correct age in each case. Items are especially important. Physicians: please write carefully and fill in all items.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4 1942, at 6:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 3 1942, to Oct. 4 1942, and that I last saw her alive on Oct. 4 1942.

Immediate cause of death	Duration
Prematurity	1 day
Due to.....	
Due to.....	
Other Conditions.....	

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature J. Neill Spangler M.D.
Address Johns Hopkins Hosp. Date signed 9-5-47

5925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V 161c

Registered No. 655925

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry must be made in this office. Do not write in space below. Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ days.
(e) Length of stay in Baltimore (yrs., mos., or days) 1½ days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore, Middle River, 20, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 25 Pickford Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Frank Vlatowski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/7/47

8. AGE: Years	Months	Days	If less than one day
		1	8 hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry Frank Vlatowski
13. Birthplace Hartleton, Penn.

MOTHER
14. Maiden Name Wanda J. Reahl
15. Birthplace Camden N. J.

16 (a) Informant John Henry Frank Vlatowski
(b) Address 25 Pickford Drive

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 9 1947
18 (a) Funeral director Commissioner of Health
(b) Address
OCT 11 1947 Huntington Williams, M.D.
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/8/47 19 , at 3:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/7/47 19 , to 10/8/47 19 , and that I last saw h[er] alive on 19

Immediate cause of death: Respiratory failure	Duration
Due to	
Due to	
Other Conditions: Mother had toxemia during pregnancy. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: Oedema of brain

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Waldrop
Address WBGH Date signed 10/8/47

X

55926 BCH 690723

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 157a

✓ 655926 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hos
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 734 S. Decker Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maria Pamela Fischer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-4-47

8. AGE: Years | Months | Days: 3 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name William Bernhard Fischer

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Pamela Fischer Groswell

15. Birthplace England

16 (a) Informant Father - William Fischer

(b) Address 734 S. Decker Ave. 24

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School OCT 9, 1947

18 (a) Funeral director Commissioner of Health

(b) Address

OCT 11 1947 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/7/47, 19 at 3 P.M.

21. I certify that death occurred on the date above stated, from the following ed deceased from 10/4/47 to 10/7/47, 19 and that I last saw h[illegible] alive on 10/6/47

Immediate cause of death	Duration
respiratory failure	
Due to Hydrocephalus	
Due to Spina bifida	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: spina bifida

of autopsy: At the cisterna

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. S. Waldrop

Address WBGH Date signed 10/8/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

1927 D.O.A.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159 Registered No. G55927

PLEASE WRITE PLAINLY, with pen and ink. Use the causes of death clearly and legibly. correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 134 Fleming Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Broadway

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: —

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 2 1947

8. AGE: Years | Months: 3 hrs | Days: - | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Harlie Broadway
13. Birthplace N.C.

MOTHER 14. Maiden Name Octavia Little
15. Birthplace N.C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Johns Hopkins Medical Schoo OCT 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 11 1947 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1947, at 4 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 1947 to Oct 2 1947 and that I last saw h.s.w. alive on Oct 2 1947.

Immediate cause of death	Duration
D.O.A.	
ASPHYXIA NEONATORUM	
Due to	
Due to PREMATURITY	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William A. Spencer M.D.
Address Johns Hopkins Hosp. Date signed 10/3/47

OK-a Dr. Davis
Nathaniel Potter

5928 BC# B-90821

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ 159

Registered No. 655928

PLEASE WRITE PLAINLY, with ink. Fill in all blanks. Be sure and write the causes of death clearly and legibly. Give exact residence and correct age is especially important. Physicians: please write the cause to which death should be charged statistically.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 601 N. Broadway
(c) Hospital or institution:
The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3414 Chessell Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Foore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			2 hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Max Foore
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Frances Leeper
15. Birthplace Pennsylvania

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo OCT 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) OCT 11 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 1947 at 6.55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 6 1947 to Oct. 6 1947. and that I last saw h im alive on Oct. 6 1947

Immediate cause of death	Duration
Premature Labor	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. C. Williams M. D.
Address Johns Hopkins Hospital Date signed 10-9-47

X

G55929

BC# B-90228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

G55929
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 605 W. Lanvale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Baby Boy Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	negro	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/18/47

8. AGE: Years	Months	Days	If less than one day
0	0	11	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name ? Brown
13. Birthplace

MOTHER
14. Maiden Name Cordia Brown
15. Birthplace Fla.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 2, 1947

18 (a) Funeral director Commissioner of Health
(b) Address

OCT 11 1947 (Date rec'd by registrar) Hamilton Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29 1947, at 12:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/18 1947, to 9/29 1947, and that I last saw h[illegible] alive on 9/28 1947

Immediate cause of death respiratory failure

Due to acute dural hemorrhage

Due to depressed fracture skull - post operative

Other Conditions, jaundice intestinal obstruction?
(Include pregnancy within 3 months of death)

Date of operation 9/29/47

Major findings of operation: depressed skull fracture, lacerated

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Helen White, M.D.

Address University Hosp. Date signed 9/29/47

G55930 **HEALTH DEPARTMENT—CITY OF BALTIMORE** G55930

BC# 591063 **CERTIFICATE OF DEATH** 159

1. PLACE OF DEATH Volunteers of Amer. Hospt. Registered No.

CITY OF BALTIMORE: (No. 4186 W. Lexington St. St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Juanita Ward If U. S. Veteran specify WAR

(a) Residence: No. 1527 Bank St. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	W	Single

3a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) Oct. 1, 1947

7. AGE Years	Months	Days	If LESS than 1 day, 17 hrs. or min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Balto Md

FATHER
13. NAME Wesley Jones
14. BIRTHPLACE (city or town) (State or country) Balto Md.

MOTHER
15. MAIDEN NAME Elizabeth Ward
16. BIRTHPLACE (city or town) (State or country) Balto Md.

17. INFORMANT Elizabeth Ward
(Address) 1527 Bank St.

18. BURIAL, CREMATION, OR REMOVAL
Place University Medical School OCT 3, 1947 19

19. UNDERTAKER Commissioner of Health
(Address)

OCT 11 1947 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Oct. 1, 1947

22. I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1947, to Oct. 1, 1947

I last saw her alive on Oct. 1, 1947 Death is said to have occurred on the date stated above, at 6.45 p m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Erythro Pelagra Toxic Infection	at birth

Other contributory causes of importance:

Prematurity

Was an operation performed? Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) [signature] M. D.
(Address) Volunteers of America Hosp.

state CAUSE OF DEATH in plain terms. Do not use abbreviations or symptoms. OCCUPATION is very important. See instructions on back of certificate.

55931 DCH B-90262 BALTIMORE CITY HEALTH DEPARTMENT ✓ C55931 Registered No. 1

CERTIFICATE OF DEATH 161a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 106 West West Street
(c) Hospital or institution:
Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 min
(e) Length of stay in Baltimore (yrs., mos., or days) 30 min

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 106 West West Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Clifford Sheets Sheets

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	negro	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 30, 1947

8. AGE: Years	Months	Days	If less than one day
			hr. 30 min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation New born
11. Industry or business

FATHER
12. Name Robert Lee Sheets
13. Birthplace York County - South Carolina

MOTHER
14. Maiden Name Lucille May Russell
15. Birthplace Brunswick, Georgia

16 (a) Informant mother
(b) Address 106 W. West Street

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 1947

18 (a) Funeral director Commissioner of Health
(b) Address

OCT 11 1947 (Date rec'd by registrar) H. Bentley Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-30-47 1947, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 30 1947, to Sept 30 1947, and that I last saw h... alive on Sept 30 1947.

Immediate cause of death Respiratory Failure — Duration

Due to Atelectasis

Due to Medical Intervention Prolonged anesthesia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Norman L. Jennison M.D.
Address Veterans Hosp Date signed 9/30/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry of items 1 to 19 must be complete in the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

55932 B.C # B-86763

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 107

Registered No. G55932

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 W. Mulberry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth E. Wingefield

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
	1	14	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16. (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 11 1947 (Date rec'd by registrar) (Huntington Williams M.D.)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19, 1947, at 1.30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner
Date signed 9-20-47

VS 151

Physicians: please write correct age is especially important.

5933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 ✓

Registered No. B-55933

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital ?
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 238 S. Wolfe Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN BRUNO

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1856

8. AGE: Years	Months	Days	If less than one day
91			hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business Unknown

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Unknown
(b) Address

17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) OCT 11 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 181

correct age is especially important. Physicians: please write

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH September 21, 1947, at 10 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arterio-sclerotic Cardio-vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Emil H. Novy M.D.
Medical Examiner.
Date signed 9-22-47

X

55934 BCH B-89666 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. C55934

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 21 N. Exeter Street
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME BABY KING

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/8/47

8. AGE: Years | Months | Days | If less than one day: 2 hr. 8 min.

9. Birthplace.....
(Town, county, and state)

10. Usual Occupation Unknown
11. Industry or business

MOTHER / FATHER
12. Name.....
13. Birthplace

MOTHER
14. Maiden Name.....
15. Birthplace

16 (a) Informant.....
(b) Address Unknown

17 (a).....(b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location University Medical School OCT 1947

18 (a) Funeral director Commissioner of Health
(b) Address.....

19 (c) OCT 11 1947 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION 45 P.

20. DATE OF DEATH September 19, 1947, at 12 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Congenital Atelectasis

Due to Prematurity

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Edward V. Piper M.D.
Medical Examiner
Date signed 9-20-47

Please write clearly. Physicians: please write the cause of death correctly. Correct age is especially important.

55935 BC# B 92420 BALTIMORE CITY HEALTH DEPARTMENT 159 Registered No. G55935

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use no abbreviations. Be sure to write the causes of death clearly and legibly. Underlining is especially important. Physicians: please write correct age in years, months, days, hours, minutes.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore.
(c) City or town Dundalk. (If outside city or town limits, write RURAL and give town)
(d) Street No. 7241 Holabird Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby boy Ebert
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: male
5. Color or race: White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 9-30-47
8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Anthony Ebert
13. Birthplace

MOTHER
14. Maiden Name Adeline Ebert Lenz
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Local Johns Hopkins Medical Schoo OCT 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 11 1947 (Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-1- 1947 at 1 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-30-1947 to 10-1-1947 and that I last saw him alive on 10-1-1947

Immediate cause of death ASPHYXIA NEONATORUM — Duration

Due to ATELECTASIS

Due to

Other Conditions PREMATURITY

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. Spencer M.D.
Address Johns Hopkins Hosp Date signed 10/2/47

655936

CWK-95090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

469

Registered No. 655936

PLEASE WRITE PLAINLY, with ink and use no abbreviations. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Years
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1028 Fulton Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 27-1870

8. AGE: Years	Months	Days	If less than one day
77	5	3	hr. min.

9. Birthplace Scotland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Smith (D)
13. Birthplace Scotland

MOTHER
14. Maiden Name Mary Ackfor (D)
15. Birthplace Scotland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 11 1947 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 30 19 47, at 11:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 19 45 to Sept. 30 19 47, and that I last saw h. in alive on Sept. 30 19 47.

	Duration
Immediate cause of death Generalized carcinomatosis	7 weeks
Due to Carcinoma of the head of the pancreas	10 mos.
Due to	
Other Conditions Thrombophlebitis 4 legs	4 days

(Include pregnancy within 3 months of death)

Date of operation 8/16/47
Major findings of operation: inoperable Ca of the pancreas
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gordon Craft M. D.
Address Baltimore City Hosp. Date signed 10/7/47

VS 150

55937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

G55937 Registered No.

GM. 112885

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern AVE.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Month
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 307 N. Exeter ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert, Butler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
?55			hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records Balto. City Hospitals
(b) Address 4940 Eastern AVE.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3 - 1947, at 1.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 9 - 1947 to Oct. 3 - 1947 and that I last saw him alive on Oct. 3 - 1947.

Immediate cause of death	Duration
Pulmonary atelectasis, ? ff	Hours
Due to "Post-operative"	
Due to Carcinoma (Bronchogenic) Rt. Lung	2 Months
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Sept 30, 47

Major findings of operation: Carcinoma Rt Lung

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ernest E. Rottenwell M.D.
Address Balt. City Hosp. Date signed Oct 9, 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Fill in all blanks; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

55938 JL - 114159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. G55938

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Anne Arundel
(c) City or town Baltimore Crownsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Crownsville State Hospital
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joshua Castor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20, 1874

8. AGE: Years	Months	Days	If less than one day
73	1	10	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Castor
13. Birthplace Va.

MOTHER
14. Maiden Name Ruth Johnson
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 1947

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 19 47 at 3.50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 29 1947 to Sept. 30 1947 and that I last saw h. im alive on Sept. 30 1947

Immediate cause of death	Duration
Dehydration and Uremia	2 Days
Due to Intestinal Obstruction	?
Due to Carcinoma of the Sigmoid Colon	months
Other Conditions,	

(Include pregnancy within 3 months of death)

Date of operation Sept 29, 1947

Major findings of operation: Carcinoma of Sigmoid & obstruction

of autopsy: See Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul E. Nutterville M.D.

Address Baltimore City Hosp. Date signed Oct 7, 47

655939

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

655939 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 501 Burke St.
(c) Hospital or institution: Baltimore City Jail
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 740 W. Saratoga St.
(If rural give location)
(e) Citizen of foreign country? ——— (Yes or No)
If yes, name country ———

3 (a) FULL NAME Edith Doty

3 (b) If veteran, name war ———
3 (c) Social Security Account No. ?

4. Sex Female
5. Color or race Colored
6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years 47 | Months | Days | If less than one day hr. min.

9. Birthplace Westminster Md
(Town, county, and state)

10. Usual Occupation Domestic
11. Industry or business ———

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Warden C. F. Price
(b) Address Balto City Jail

17 (a) ——— (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 1947

18 (a) Funeral director Commissioner of Health
(b) Address ———

19 (a) 11 W (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/27/1947, at 11:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/21/1947 to 9/27/1947 and that I last saw h... Ex alive on 9/27/1947.

Immediate cause of death: Myocardial Insufficiency — Duration 4 hrs
Due to: Myocarditis — 6 mos
Due to: Mitral Insufficiency — 6 mos
Other Conditions ———
(Include pregnancy within 3 months of death)
Date of operation ———
Major findings of operation: ———
of autopsy: ———

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence ——— at ——— M
(c) Where did injury occur? ——— (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ——— (Specify type of place) While at work? ———
(e) Means of injury ———
23. Signature Thomas J. Pentz
Address Balto City Jail Date signed 9/27/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Be sure to correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G55940

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G55940 Registered No.

Every item must be answered. Please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Cold Spring Lane
(c) Hospital or institution: Elking Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Y
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 240 E 22nd St. (Balto Md) (If outside city or town limits, write RURAL and give town)
(d) Street No. 240 E 22nd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Joseph McCormack

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business City of Balto.

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Mary Moore
(b) Address 302 Barclay St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 10-13-47 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Wiedefeld & Son
(b) Address Greenmount Ave & 22nd St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

OCT 14 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-9-47 19 . at 7:- P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1 1946 to 10-9 1947 and that I last saw h[illegible] alive on 10-8 1947.

Immediate cause of death GENERALIZED ARTERIOSCLEROSIS. — Duration 5 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herman R Kegan M. D.
Address 3503 Edmondson Ave Date signed 10/14/47

HENDERSON

G55941

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55B

G55941 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 341 E 20th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 341 E 20th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alex B Henderson

3 (b) If veteran, name war —

5 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Elise

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15 1887

8. AGE: Years 60 | Months - | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Penna R.R.

FATHER 12. Name Alexander B. Henderson

13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Genevive Easter

15. Birthplace Baltimore Md.

16 (a) Informant Florence Combs

(b) Address 341 E 20th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 13 1947 (month) (day) (year)

(c) Cemetery or crematory Greenmount

Location Greenmount & Oliver

18 (a) Funeral director John G Horan

(b) Address 3000 E Baltimore St

19 (a) 10/12/47 (Date received by registrar) (b) Huntington Williams, Md Registrar

V S 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. correct, age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 9th 1947, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-2 1947 to 10-9 1947 and that I last saw him alive on 10-9 1947.

	Duration
Immediate cause of death: Hodgkin's Disease	1 yr.
Due to: generalized	years
Due to:	
Other Conditions: Syncope	1 yr.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature O. B. Hyson M. D.

Address 11 E. Chase St. Date signed 10-10-47

X

G55942 BALTIMORE CITY HEALTH DEPARTMENT G55942 Over
CERTIFICATE OF DEATH 1937 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use no abbreviations. Do not write the causes of death clearly and legibly. correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4301 ROLAND AVE.
(c) Hospital or institution:
KIRKLEIGH VILLA.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 8. MONTH
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4505 Keswick Road 5329 UNIVERSITY PARKWAY
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME EDITH ~~F~~ D STEIN.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife T. Ferguson Stein
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) ----------

8. AGE: Years	Months	Days	If less than one day
65	---	---	-- hr. -- min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business -----

FATHER
12. Name Eugene L. Didier
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Louise Northrop
15. Birthplace Charleston, S. Carolin

16 (a) Informant Miss Angela DeB. Didier
(b) Address 4505 Keswick Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/47 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH OCTOBER 10 1947 at 1215 M

21. I certify that death occurred on the date above stated; that I attended deceased from JANY 27 1947 to OCT 10 1947 and that I last saw her alive on OCT 10 1947.

Immediate cause of death	Duration
APOPLEXY OCTOBER	9.1947
Due to MYOCARDIAL DEGENERATION	1946.
Due to ARTERIOR SCLEROSIS.	1946.
Other Conditions POST OPERATIVE ABDOMINAL HERNAE (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy: NONE	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos. P. Stein
Address 3013 ST PAUL STREET Date signed OCTOBER 10TH 1947

655943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 49a

655943 Registered No.

PLEASE WRITE PLAINLY. WITH UNFADING INK. Every item of information must be given. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3312 Chestnut Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3312 Chestnut Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edna I. Charters.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jerome E. Charters

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 28, 1896

8. AGE: Years: 51 | Months: 1 | Days: 11 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, state or state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Wm H. Cornell
13. Birthplace Maryland.

MOTHER
14. Maiden Name Nora A. Sewell
15. Birthplace Maryland

16 (a) Informant Jerome E. Charters
(b) Address 3312 Chestnut Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 11/47 (month), (day), (year)
(c) Cemetery or crematory St. Mary's
Location Hamden Md

18 (a) Funeral director Chenoweth & Donovan
(b) Address 3615-17 Chestnut Ave

19 (a) 10/12/47 (Date rec'd by registrar) (b) Christopher Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8, 1947, at 11 05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 1947 to Oct 8 1947, and that I last saw h[illegible] alive on Oct 8 1947.

Immediate cause of death: (a) Renal Uremia carcinomatosis — Duration: 1 yr.

Due to: (b) Following operation for Removal right breast about June 1946 — Duration: 1 yr.

Due to: (c) — Duration:

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation June 1946.

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jean Donovan

Address 3615 Chestnut Ave. Date signed Oct 10 1947.

X

G55944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G55944 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every question must be answered. Please write the causes of death clearly and legibly. Correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 861/2 W. Hamilton
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 86 1/2 W. Hamilton (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank C. McAbee

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Laura McAbee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1, 1895

8. AGE: Years: 52 | Months: 8 | Days: 7 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER 12. Name: Unknown.
13. Birthplace: "

MOTHER 14. Maiden Name: "
15. Birthplace: "

16 (a) Informant: Mrs. Laura McAbee
(b) Address: 1110 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 11, 1947 (month) (day) (year)
(c) Cemetery or crematory: Mt. Auburn
Location

18 (a) Funeral director: Mrs. K. R. Williams
(b) Address: 322 N. Schroeder St

19 (a) (Date received by registrar) (b) Registrar: Lexington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 - 8 - 1947, at 7:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15, 1947 to Oct 8, 1947 and that I last saw h. was alive on Oct 7, 1947

	Duration
Immediate cause of death: Coronary Sclerosis	1 hr mo
Due to: Chronic Carditis	3
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: John E. L. Campbell
Address: 639 N. Carey St. Date signed 10-11-47 M. D.

G55945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82a

G55945 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every question must be answered. Write the causes of death clearly and legibly. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 111 N Carey St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 111 N Carey St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isabel Hammondis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25, 1867

8. AGE: Years 80 | Months 6 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Walter Hammondis
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Mary E. Griffith
15. Birthplace Balto Md

16 (a) Informant Mrs Charles Gibson
(b) Address Catonsville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/47 (month) (day) (year)

(c) Cemetery or crematory Green Mount
Location Baltimore Md

18 (a) Funeral director William A. Lee
(b) Address 1517 E Fort Ave

19 (a) Oct 12 1947 (Date received by registrar) (b) Huntington Williams Registrar

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 10 1947, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1947 to Oct 10 1947 and that I last saw h ER alive on Oct 10 1947

Immediate cause of death: Cerebral Hemorrhage. — Duration: 2 days

Due to: Arteriosclerosis — 20 yrs.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Arthur J Davis M. D.

Address 800 W 32nd St Date signed 10-11-47

X

G55946 G55946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 137 E. Cross St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 137 E. Cross St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Huber

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Paul C. Huber
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17, 1875

8. AGE: Years	Months	Days	If less than one day
72	3	23	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown Helmrich
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown Unknown
15. Birthplace Germany

16 (a) Informant James A. Huber
(b) Address 137 E. Cross St

17 (a) Burial (b) Date thereof 10-14-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Ritchie Highway
18 (a) Funeral director Wm. Cook, Inc.
(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10, 1947, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1946 to Oct. 10, 1947. and that I last saw h[illegible] alive on 10-10 1947.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 wk.
Due to Arteriosclerosis	3 yrs.
Due to	
Other Conditions Chronic Myocardial Degeneration	2 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature A. Hallock M. D.
Address 207 Y. T. Ave. Date signed 10-11-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

83a

G55947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 1319

G55947 Registered No.

Please write plainly, with unfading ink. Every item must be answered. Write the cause of death clearly and legibly. Correct age is especially important. Physicians: please write legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 928 Poplar Grove St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 928 Poplar Grove St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elenora M Kreba

3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race White
6. Single, married, widowed, or divorced Widow
6 (b) Name of husband or wife Edwin N.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec 29 1874
8. AGE: Years 72 | Months 9 | Days 11 | If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Hagner
13. Birthplace Balto Md

MOTHER
14. Maiden Name Mona Madden
15. Birthplace Maryland

16 (a) Informant Mrs George Mauldy
(b) Address 928 Poplar Grove St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/47 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Md
Location Baltimore Md

18 (a) Funeral director Wilson & Son Inc
(b) Address 1314 Park Ave

19 (a) 1947 (Date rec'd by registrar) (b) Livingston Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 10 1947, at 6 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1st 1944, to Oct 10th 1947, and that I last saw her alive on Sept 2nd 1947.

	Duration
Immediate cause of death: Coronary Occlusion	4 hrs.
Due to: Arteriosclerosis	8 yrs.
Due to: Chronic Nephritis	3 yrs.
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. Van Devender M. D.
Address 1136 Poplar Grove St Date signed 10/11/47

X

G55948 64 BALTIMORE CITY HEALTH DEPARTMENT G55918
Registered No.

CERTIFICATE OF DEATH 1947a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Cambridge Lying-in Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Forest 34th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mabel I Epley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 10, 1884

8. AGE: Years 58 | Months 0 | Days 1 | If less than one day hr. min.

9. Birthplace Michigan
(Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace "

MOTHER 14. Maiden Name "
15. Birthplace

16 (a) Informant Henrietta Hershey
(b) Address Cambridge Lying-in Hosp

17 (a) Burial (b) Date thereof 10/13/47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Wilbert Lee
(b) Address 1214 N Fulton Ave

19 (a) (b)
(Inscribed by registrar) (Signature of registrar)

10 17 1947

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Use "None" or "Unknown" where necessary. Be sure to write the cause of death clearly and legibly. Physicians: please write correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11° 1947, at 5:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1, 1947 to Oct. 10, 1947 and that I last saw her alive on Oct. 10, 1947.

	Duration
Immediate cause of death Coronary occlusion	4 days.
Due to	
Due to	
Other Conditions Deforming arthritis (Include pregnancy within 3 months of death)	10 yrs.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Willis Guyton M. D.
Address 3963 Greenmount Ave Date signed 10/11/47

X

G55949

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83c

G55949

Every item of information must be answered. Please write plainly, with unfading ink. Physicians; please write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2900 Parkwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 1yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2900 Parkwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adolf Neuberger

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mator

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 71 | Months 6 | Days | If less than one day: hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Simone
13. Birthplace Germany

MOTHER
14. Maiden Name Sarah
15 Birthplace Germany

16 (a) Informant Mator Neuberger
(b) Address 2900 Parkwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-47 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 2400 Eastern Blvd

19 (a) (b) Registrar Huntington Williams M.D.

OCT 12 1947

V S 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-11-1947 at 12:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1946 to 10/10/1947 and that I last saw h[illegible] alive on 10/10/1947

Immediate cause of death: Encephalomalacia — Duration: one yr

Due to: ~~Syncope Cause & Records~~ Hypertension

Due to: Gener. Arteriosclerosis

Other Conditions: Ultimate Pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Neuberger M.D.

Address 912 Brooks Lane Date signed 10/11/47

G55950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

G55950 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item to be answered. If unknown or if not applicable, write word unknown or cross out. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 615 Homestead St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 615 Homestead St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Hamill

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Grace W. Hamill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18, 1868

8. AGE: Years 79 | Months 4 | Days 22 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Yeast Mfgr.

11. Industry or business Self

FATHER
12. Name Robert W. Hamill
13. Birthplace Ireland

MOTHER
14. Maiden Name Olivia Hamill
15. Birthplace Maryland

16 (a) Informant Mrs. Grace W. Hamill
(b) Address 615 Homestead St.

17 (a) Burial (b) Date thereof Oct. 13, 1947
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Pikesville, Md.

18 (a) Funeral director E. Wilbs Lemmon
(b) Address 4510 Liberty Heights Ave.

19 (a) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

OCT 12 1947

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 10 1947, at 12 noon

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 17 1947 to Oct 10 1947 and that I last saw him alive on Oct 9 1947.

Immediate cause of death: Myocarditis
Arteriosclerosis
Duration: Gradual

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W H Healy M. D.
Address 1403 Park ave Date signed Oct 13 1947

X

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 8-26 DAY OF 1963 THE MICROPHOTOGRAPHS APPEARING HEREIN STARTING WITH 52626 AND ENDING WITH 55950 ARE ACCURATE AND COMPLETE REPRODUCTIONS OF THE RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics AS DELIVERED IN THE REGULAR COURSE OF BUSINESS FOR PHOTOGRAPHING, AND THAT:

TO THE BEST OF MY KNOWLEDGE THE MICROFILM MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC COPY.

CAMERA OPERATOR: Loretta Byrne

END OF REEL